Such services are funded in part with the State of New Mexico.

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
# Blue Cross Community Centennial Section of the *Blues Provider Reference Manual*

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The Blue Cross Community Centennial Plan

Introduction

HCSC Insurance Services Company (HISC), a wholly-owned subsidiary of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, has contracted with the State of New Mexico, Human Services Department, Medical Assistance Division (HSD/MAD), to offer a Centennial Care plan named Blue Cross Community Centennial℠. Blue Cross and Blue Shield of New Mexico (BCBSNM), a Division of HCSC, has contracted with HISC to administer this program.

This section applies to physicians, professional providers and facility providers who have agreed to participate as Blue Cross Community Centennial providers and who have signed agreements in place. This addendum, along with the Blues Provider Reference Manual, explains the policies and procedures of the BCBSNM network. It provides you and your office staff with important information as you serve Blue Cross Community Centennial members, and is incorporated by reference into your New Mexico Medicaid Managed Care Amendment or Agreement, as applicable, with BCBSNM. The information is likely to apply in most situations your office will encounter while participating in these programs. This section of the Blues Provider Reference Manual is applicable only to the operation of the Blue Cross Community Centennial plan.

Blue Cross Community Centennial Network

Blue Cross Community Centennial is a Medicaid Managed Care Plan that focuses on breaking down the financial, cultural, and linguistic barriers preventing low-income families and individuals from accessing health care. BCBSNM maintains and monitors a network of participating physicians and professional providers (including physicians, hospitals, behavioral health providers, long term care providers, skilled nursing facilities, ancillary providers, and other health care providers) through which members obtain covered services.
Program Overview

The Blue Cross Community Centennial plan is the modernization of the Medicaid program as developed by New Mexico Human Services Department under an 1115 waiver application to Center for Medicaid & Medicare Services (CMS). Under Blue Cross Community Centennial, BCBSNM will provide a seamless program for Medicaid eligible individuals to meet their health care needs across the full array of Medicaid services, including acute and long term care, behavioral health care, and home and community based services. A fundamental focus of the Blue Cross Community Centennial plan will be to identify members at highest risk of poor health outcomes, using a person-centered approach, developing personalized plans, and ensuring that necessary services are provided.

This integrated care approach focuses on health literacy, utilization of community partners to assist members in navigating the health care system, comprehensive care coordination, ongoing development of patient-centered primary care medical homes, and the future development of health homes. This infrastructure will help assure that members receive the care they need in a timely manner while enabling increased quality and better health outcomes.

BCBSNM Medicaid members will each receive a Health Risk Assessment (HRA) upon entry into the program. The HRA will be conducted annually or more frequently as clinically indicated in order to continuously screen for risks or unmet health needs. Completion of the HRA is the responsibility of BCBSNM in collaboration with the member or their caregiver. The HRA screens for physical health, behavioral health and long-term health care needs.

The HRA results will be used to risk stratify all BCBSNM Medicaid members as either being Low Risk (level 1), Moderate Risk (level 2), or High Risk (level 3). Face-to-face comprehensive needs assessment will be conducted with any member initially risk stratified at either a Level 2 or Level 3, in order to confirm their risk level status. A BCBSNM Care Coordinator will use the information collected during the comprehensive needs assessment process to develop a care plan. The Care Coordinator will seek input from providers during the needs assessment process in order to ensure that the care plan is comprehensive and that the resulting care plan meets the needs of each member.

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Ongoing care coordination will be provided to members to ensure that appropriate services are being accessed, that the appropriate providers are connected as needed, that service gaps are identified, and that any identified service-related needs are resolved in a timely manner.

Care coordination activities will be provided at the level needed by the individual member but *at least minimally* as follows:

- **Level 1**: Annual HRA, health education, referrals as needed, quarterly review of claims and utilization data to screen for potential higher level needs. Call center for urgent needs.
- **Level 2**: Member assigned a specific care coordinator. Annual comprehensive needs assessment, semi-annual face to face visit, and quarterly telephone contact with member, care plan development and monitoring, health and disease management education, potential assignment to a health home.
- **Level 3**: Member assigned a specific care coordinator. Semi-annual comprehensive needs assessment, quarterly face to face visit, monthly telephonic contact, care plan development and monitoring, health and disease management education, potential assignment to a health home.

Whether directly providing care coordination or some other health care service, providers throughout the system of care will be better prepared to provide quality care by understanding and participating in care coordination activities. The level of participation may vary depending on individual member needs, but might include: sharing or receiving information from an assigned care coordinator, being aware of the member's overall care plan, participating in integrated care planning, and the like. Through this process, BCBSNM will continuously monitor member level data and provide reports to providers in as appropriate.
For more information regarding the Care Coordination program and the role of the provider, please contact BCBSNM Network Services at 505-837-8800 or 1-800-567-8540.

You may also contact BCBSNM Health Care Management at 505-291-3585 or 1-800-325-8334.

This is an important partnership between providers, members, and BCBSNM. We look forward to working with you to meet the health care needs of the BCBSNM Medicaid members.

After a Blue Cross Community Centennial member enrolls with BCBSNM (whether as the result of selection or auto-assignment), members have one opportunity anytime during the 90 calendar-day period immediately following the effective date of enrollment with BCBSNM to request to change to another Blue Cross Community Centennial Managed Care Organization (MCO). After exercising this right to change MCOs, a member will remain with the MCO until the annual choice period, unless the member is disenrolled.

Blue Cross Community Centennial members are allowed to change MCOs every 12 months at the time of the member’s redetermination. Members who do not select another MCO during their annual choice period will be deemed to have chosen to remain with their current MCO. Members who select a new MCO during their annual choice period shall have one opportunity anytime during the 90 calendar-day period immediately following the effective date of enrollment in the newly selected MCO to request to change MCOs.
Managed Care Program participation: A Medicaid member will need to pick a Managed Care plan at the Income Support Division (ISD) office. All members, except for Native American members, must pick a managed care plan.

Auto assignment: If a member does not pick an MCO while filling out their Medicaid application, they will be randomly assigned to one unless one of the following occurs:

- If a member was previously enrolled with an MCO and had a term status for two months or less, they will be assigned back to their original MCO upon reinstatement.
- Family members will be assigned to the same household MCO.
- Newborns will be covered by the same MCO as their mother.

Reenrollment: Most members must renew Medicaid coverage every 12 months. This can be done through the ISD office or in some cases by calling HSD at 1-888-997-2583.

Coverage due to pregnancy: Some women are eligible for Medicaid because they are pregnant. Coverage for these members lasts for two months after the pregnancy has ended.

Newborns: Medicaid-eligible newborns have coverage for 12 months starting with the month of birth. If the mother is enrolled in an MCO, the child is enrolled in the same MCO. The baby’s MCO can be changed if the mother (or legal guardian) requests it for up to 90 calendar days after the newborn’s birth. After the baby is born, the hospital will complete the Notice of Birth form, which is sent to the mother’s MCO. It is very important for the mother to tell the ISD caseworker right away that the baby has been born. They will work with the MCO to order and mail ID cards to the member.

Change in eligibility and/or address: A significant amount of important information is mailed to the address the member gives to the ISD office. If the member changes addresses, it is very important they call their ISD office right away and give them their new address.

Continued on next page
Program Overview, Continued

When the member should contact their ISD Case Worker: The patient will need to call their county ISD case worker if they:
- Change their name
- Move to another address
- Have a new child or adopt a child; place their child for adoption
- Get other health insurance, including Medicare
- Move out of New Mexico
- Have any questions about Medicaid eligibility

Medicaid eligibility is determined based on how many people are in the member’s family. If there is a change in family size, it is important for the member to report this to the ISD office right away.

Waiver eligibility: All individuals determined Medicaid eligible are required to participate in the Blue Cross Community Centennial program unless specifically excluded by the 1115(a) Waiver. Recipients in the Developmental Disabilities 1915(c) Waiver and Recipients with developmental disabilities in the Mi Via 1915(c) Waiver will continue to receive Home and Community Based Services (HCBS) through those waivers, but are required to enroll with an MCO for all non-HCBS effective 01/01/2014.

Recipients in the Medically Fragile 1915(c) Waiver will continue to receive HCBS through that waiver unless and until such services are transitioned into Blue Cross Community Centennial. Recipients in the Medically Fragile 1915(c) Waiver are required to enroll with a MCO for all non-HCBS effective 01/10/2014.

Primary Care Provider (PCP)
The primary care provider must be a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to members, initiating and/or facilitating the use of appropriate specialist care, and maintaining the continuity of the member’s care. Individuals with Special Health Care Needs (ISHCN) may designate a specialist as their primary care provider as long as that specialist agrees to act in that role.

Continued on next page
Program Overview, Continued

**PCP and Pharmacy Lock-in**

**PCP Lock-Ins:** In the event that a Blue Cross Community Centennial member is identified as continuing utilization of unnecessary and duplicative services, BCBSNM can, with the approval of the PCP or attending physician, place a PCP lock-in for the member. The PCP or attending physician can also contact the BCBSNM case manager and request a PCP lock-in on a member who is seeing multiple providers for the same services. A PCP lock-in can be done for more than one provider if indicated.

**Pharmacy Lock-Ins:** BCBSNM can require a Blue Cross Community Centennial member to utilize one pharmacy when prescription compliance or drug-seeking behavior is identified or suspected. The PCP or attending physician can also contact the BCBSNM case manager and request a pharmacy lock-in on a member who is using multiple providers for the same prescriptions.

The BCBSNM case manager, pharmacist and medical director jointly monitor the members who are in the PCP/pharmacy lock-in process, coordinate with the PCP and the pharmacy and report on these members quarterly to the State.

**24-Hour Coverage**

Participating PCPs are expected to provide coverage for members 24 hours a day, 7 days a week. When a PCP is unavailable to provide services, the PCP must ensure that he or she has arranged for coverage from another PCP. Hospital emergency rooms or urgent care centers are not substitutes for covering participating providers. Please refer to the Blue Cross Community Centennial Provider Finder® online at www.bcbsnm.com to identify providers participating in the Blue Cross Community Centennial network. You may also contact the Customer Service Department at the number listed on the back of the member’s identification (ID) card with questions regarding which providers participate in the Blue Cross Community Centennial network. Core Service Agencies (CSAs) are expected to provide behavioral health crisis intervention 24 hours a day, 7 days a week.

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Emergency services are health care services provided in a hospital or comparable facility to evaluate and stabilize medical or behavioral health conditions manifesting themselves by acute symptoms of sufficient severity (including severe pain). These symptoms would lead a prudent layperson possessing an average knowledge of medicine and health to reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or the unborn child) in:

- Serious jeopardy of the patient’s health
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement

Emergency Care services necessary to evaluate and stabilize an emergency medical condition are covered by Blue Cross Community Centennial. Members with an emergency medical condition should be instructed to go to the nearest emergency provider. Evaluation and stabilization of an emergency medical condition in a hospital or comparable facility does not require preauthorization.

The attending emergency physician or the provider actually treating the Blue Cross Community Centennial member is responsible for determining when the member is sufficiently stabilized for transfer or discharge and that determination is binding on the entities identified in 42 C.F.R. § 438.114(b) as responsible for coverage and payment. In addition, BCBSNM is financially responsible for Post-Stabilization services administered to maintain, improve or resolve the member’s stabilized condition if:

(i) BCBSNM does not respond to a request for pre-approval within one hour;
(ii) BCBSNM cannot be contacted; or
(iii) BCBSNM’s representative and the treating physician cannot reach an agreement concerning the member’s care and a BCBSNM clinical representative or BCBSNM Medical Director is not available for consultation. In this situation, BCBSNM must give the treating physician the opportunity to consult with a BCBSNM clinical representative or BCBSNM Medical Director and the treating physician may continue with care of the member until a BCBSNM clinical representative or BCBSNM Medical Director is reached or one of the criteria of 42 C.F.R. § 422.113(c)(3) is met.
Program Overview, Continued

Emergency Services (continued)

Acute general hospitals are reimbursed for emergency services provided in compliance of federal mandates, such as the “anti-dumping” law in the Omnibus Reconciliation Act of 1989, P.L. (101-239) and 42 U.S.C. Section 1935dd. (1867 of the social Security Act).

Core Service Agencies (CSAs) must provide crisis intervention 24 hours a day, 7 days a week to triage and intervene if their members present in a behavioral health crisis.

Experimental Procedures and Items

Experimental or investigational procedures, technologies, or therapies, as defined in 8.325.6 NMAC, “Experimental or Investigational Procedures, Technologies or Non-Drug Therapies” are not covered [8.305.7.12 NMAC - Rp 8.305.7.12 NMAC, 7-1-04; A, 7-1-05].

In general, experimental, investigational, or unproven means the procedure, technology, or therapy meets any of the following conditions:

- Current authoritative medical and scientific evidence regarding the medical, surgical, or other health care procedure or treatment, including the use of drug(s), biological product(s), other product(s), or device(s) for a specific condition shows that further studies or clinical trials are necessary to determine benefits, safety, efficacy, and risks, especially as compared with standard or established methods or alternatives for diagnosis and/or treatment outside an investigational setting.
- The drug, biological product, other product, device, procedure, or treatment (the “technology”) lacks final approval from the Food and Drug Administration (FDA) or any other governmental body having authority to regulate the technology.
- The medical, surgical, other health care procedure, or treatment, including the use of drug(s), biological product(s), other product(s), or device(s) is the subject of ongoing phase I, II, or III clinical trials or under study to determine safety, efficacy, maximum tolerated dose, or toxicity, especially as compared with standard or established methods or alternatives for diagnosis and/or treatment outside an investigational setting.
- [2/1/95; 12/1/99; 8.325.6.12 NMAC - Rn, 8 NMAC 4.MAD.765.2 & A, 6-1-03]
Medically Necessary Services

In interpreting medical necessity for the Blue Cross Community Centennial plan, BCBSNM follows MR:03-52, 8.302.1.7 NMAC – N, 12-1-03 where medically necessary services are defined as:

1. Clinical and rehabilitative physical, or behavioral health services that:
   - Are essential to prevent, diagnose, or treat medical conditions or are essential to enable the individual to attain, maintain, or regain functional capacity;
   - Are delivered in the amount, duration, scope, and setting that is clinically appropriate to the specific physical, mental, and behavioral health care needs of the individual;
   - Are provided within professionally accepted standards of practice and national guidelines;
   - Are required to meet the physical and behavioral health needs of the individual and are not primarily for the convenience of the individual, provider, or payer.

2. Application of the definition:
   - A determination that a health care service is medically necessary does not mean that the health care service is a covered benefit or an amendment, modification, or expansion of a covered benefit.
   - The department or its designee making the determination of the medical necessity of clinical, rehabilitative, and supportive services consistent with the Medicaid benefit package applicable to an eligible individual shall do so by:
     a. Evaluating individual physical and behavioral health information provided by qualified professionals who have personally evaluated the individual within their scope of practice; who have taken into consideration the individual’s clinical history, the individual’s unique circumstances, including the impact of previous treatment and service interventions; and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate;
     b. Considering the views and choices of the individual or the individual’s legal guardian, agent, or surrogate decision maker regarding the proposed covered service as provided by the clinician or through independent verification of those views, and;
     c. Considering the services being provided concurrently by other service delivery systems.

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3. Physical and behavioral health services shall not be denied solely because the individual has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration, or scope to an otherwise eligible individual solely because of the diagnosis, type of illness, or condition.

4. Decisions regarding benefit coverage for children shall be governed by the Early & Periodic Screening, Diagnosis & Treatment (EPSDT) coverage rules.
**Program Overview, Continued**

**Covered Services**

The services listed below are covered under the Blue Cross Community Centennial plan.

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<td>Prosthetics and Orthotics</td>
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[1] Experimental and investigational procedures, technologies or therapies are only available to the extent specified in MAD 8.325.6.9 or its successor regulation.
Program Overview, Continued

Community Benefit

The Blue Cross Community Centennial plan is focused on facilitating access to care to meet members’ needs along the continuum of their health care including long term care. BCBSNM has developed a means to identify members in the community who would benefit from long term care services (to include medical, social, and behavioral health services). Members and/or their caregivers will be able to actively participate in the determination-of-need process and subsequent identification of available resources that would be aligned to address the identified needs. The objective is to provide the member as much autonomy in the process while assuring that the member benefits from a comprehensive program that would enhance and/or maintain the member’s well-being and safety.

BCBSNM provides the Community Benefit, as determined appropriate based on the comprehensive needs assessment. Eligible members have the option to select either the Agency-Based Community Benefit or the Self-Directed Community Benefit. Services are generally intended to meet the needs of members with disabilities or who are vulnerable, frail, and/or chronically ill.

The **Agency-Based Community Benefit** is the consolidated benefit of Home and Community-Based Services (HCBS) and personal care services that are available to eligible members meeting the nursing facility level of care. The services available include:

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<th>Environmental modifications</th>
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<tr>
<td>Assisted living</td>
<td>Home Health Aide</td>
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<td>Behavior support consultation</td>
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<td>Community transition services</td>
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<td>Emergency response</td>
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<tr>
<td>Employment supports</td>
<td>Skilled maintenance therapy svc.</td>
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The Self-Directed Community Benefit is for certain Home and Community-Based Services that are available to eligible members meeting nursing facility level of care. Self-direction in Blue Cross Community Centennial affords members the opportunity to have choice and control over how Self-Directed Community Benefit services are provided, who provides the services and how much providers are paid for providing care in accordance with a range of rates per service established by HSD. The services available include:

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<th>Behavior support consultation</th>
<th>Private Duty Nursing for adults</th>
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<td>Emergency response</td>
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<td>Employment supports</td>
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<td>Homemaker</td>
<td>Transportation (non-medical)</td>
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<td>Nutritional counseling</td>
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</table>

In addition to covering the services stipulated in the State Plan, BCBSNM provides additional services that bring value and improved health to members of New Mexico. The Blue Cross Community Centennial plan provides coverage for Value Added services that include integrated services specific to physical health, behavioral health, and long-term care. Certain services are dependent on annual dollars available and are not always available throughout the year to all consumers. Value added services may change from year to year. These services will include those outlined below.

**Full Medicaid benefits for pregnant women**

Pregnant women eligible for Medicaid under Category of Eligibility (COE) 035 Members are extended full Medicaid benefits. Along with non-pregnancy related medical and prescription drug services, COE 035 Members also have coverage for routine dental, vision (including eye glasses and check-ups), and transportation benefits. Dental, vision, and transportation services will be allowed in conjunction with the subcontractors LogistiCare, Davis Vision, and DentaQuest.
Program Overview, Continued

Value Added Services (continued)

**Infant car seats**
The infant car seat benefit provides members with an opportunity to receive a safe child car seat free of charge, while at the same time incentivizes members to receive prenatal services so they have a safe and healthy pregnancy and delivery.

**Portable infant cribs**
The portable infant crib benefit provides pregnant members with an opportunity to receive a portable crib free of charge and encourages safe sleeping. Along with the crib, BCBSNM provides educational materials to educate parents, caregivers, and health care providers about ways to reduce the risk for Sudden Infant Death Syndrome (SIDS) and other sleep-related causes of infant death.

**Baby diapers**
The baby diaper benefit provides eligible members with the opportunity to receive a free box of baby diapers ranging in quantity from 144-272 diapers based on the diaper size.

**Dental varnish (PCP office)**
Dental fluoride varnish is a simple, safe, painless, and affordable compound that can be applied to children’s teeth by trained non-dental professionals. This benefit is available to children from birth to three years of age. The varnish has been approved by the Federal Drug Administration since 1997 and many states currently using it report encouraging results.

**Adult routine physicals**
BCBSNM covers adult routine physicals and related testing. This includes routine services to check each member’s physical and mental health. This benefit is available to members aged 21 years and older.

**Extended adult vision benefits**
Additional adult vision coverage, for members age 21 years and older, are available for exams, lenses, and frames every 12 months. These services are allowed in conjunction with the BCBSNM subcontractor, Davis Vision.
Value Added Services (continued)

Extended lodging for homeless members
A lodging benefit is available to members who are homeless and still require extensive medical treatment post-hospital discharge, or when providing lodging would prevent an inpatient admission. This benefit is provided through the BCBSNM transportation subcontractor, LogistiCare.

Traditional medicine benefit
The traditional medicine benefit is available for Native American members for traditional or healing practices in the treatment of diagnosed medical conditions. Members are allowed two grants per calendar year, $100.00 for inpatient and $250.00 for outpatient.

Additional respite care
Additional respite care is available for up to 72 hours for members that are approved for the community benefit.

Nutritional supplements
Caloric nutritional supplements are available, such as Ensure®, to Blue Cross Community Centennial members that are receiving home- and community-based services and are in temporary need of additional calories to remain in the home and avoid being institutionalized. Criteria will be developed and will incorporate input from the member’s doctor and caregiver.

Electroconvulsive Therapy (ECT)
ECT is offered as the preferred treatment of choice for certain psychiatric conditions. These conditions may include treatment of resistant major depressive disorder, depressed patients with certain comorbid medical conditions, and patients with treatment resistant mania secondary to bipolar disorder or schizoaffective disorder. In these situations ECT may be the safest and most effective treatment. Clinical conditions must meet medical necessity for ECT. Preauthorization is required.

Continued on next page
Adult Chemical Dependency Residential Treatment Center (RTC) services
RTC services are appropriate for adults with severe medical disorders and patients with alcohol/substance abuse problems that need concentrated therapeutic services in a 24-hour supervised treatment setting prior to a return to community residence. The focus of these services is to stabilize the individual and provide a safe, supportive treatment environment during detox and/or recovery from addictions. This setting offers a high degree of security, supervision and structure.

Benefit limit: Members with comorbid serious medical illness and active chemical dependency issues in need of 24-hour supervised treatment in a chemical dependency residential setting. Length of stay not to exceed 30 days annually. Annual expenditures not to exceed $125,000. Preauthorization is required.

Transitional living for chemically dependent/psychiatrically impaired adults and children
This benefit is an emergent time-limited transitional living arrangement resulting from a step down from a higher level of care (i.e., 24-hour unsupervised care) to an identified community placement to stabilize individuals with an identified plan to return to independent living. This is considered a short term emergency.

Benefit limit: Any member evaluated for this benefit will be expected to participate in the recommended psychiatric or chemical dependency treatment while in this level of care. Annual expenditures for this level of care will not exceed $125,000. Preauthorization is required.

Inpatient detox at nonhospital-based facilities
This service allows for contracted chemical dependency treatment centers to perform detoxification services for chemically dependent members. This benefit should provide a lower cost alternative to hospital based detox.

Benefit limit: Time-limited, medically-monitored detoxification benefit, subject to ASAM detoxification medical necessity criteria. This service does not include social detoxification. Members cannot have comorbid medical conditions requiring detoxification in a hospital setting. Preauthorization is required.
Infant mental health program
These treatment services are designed to reduce the risk of social, emotional, and behavioral disorders and disruptions in the relationship between an infant and parent/caregiver. Infant mental health services address attachment and relationship problems and focus on the parent-child dyad.

The program provides early intervention, family training and counseling for child development provided for the well-being of infants, toddlers and children in relationship with their caregivers, environment and culture, and with respect for each child’s uniqueness. Benefit limit: Time-limited benefit subject to medical necessity criteria. Eligible members are those who no longer have CYFD funding sources available to them; Annual expenditures will not exceed $125,000. Eligibility: Members birth to age 3 or clear symptoms of a mental health disorder. Preauthorization is required.

Additional Information
It is the vision of BCBSNM that coupled with the benefit package offered state-wide through the Blue Cross Community Centennial plan, that this range of value added services will provide comprehensive support to all Blue Cross Community Centennial members to fit their behavioral health, physical health, community social services and long-term care needs.

We encourage providers to help us promote these value added services. Please refer members to our website, member newsletter, mailings, and other communications. We can also provide you with brochures with this information.

Telehealth Services
Telehealth (or Telemonitoring) is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. While it is preferred for providers to administer services to members in person, telehealth may be provided at remote health and medical offices in which there is no provider accessible to meet our members’ needs.

Telehealth services are offered across the State, for all Blue Cross Community Centennial members.
Telehealth Services (continued)

Telehealth services are subject to the same criteria for medical necessity and program compliance that would be used if the same services were provided directly on site by the facility or provider.

Another resource for obtaining assistance in treating some of your more complex patients is The University of New Mexico Project ECHO® (Extension for Community Healthcare Outcomes) which has a program to develop the capacity to safely and effectively treat chronic, common, and complex diseases in rural and underserved areas, and to monitor outcomes of this treatment. Providers can be reimbursed by BCBSNM to present and discuss your more complex Blue Cross Community Centennial members to an ECHO Clinic.

Behavioral Health

BCBSNM works closely with New Mexico’s Behavioral Health Collaborative (Collaborative) to partner with providers for resiliency and recovery services in all geographic regions and diverse communities throughout the state.

The BCBSNM Integrated Behavioral Health Program is a portfolio of resources that helps Blue Cross Community Centennial members access benefits for behavioral health (mental health and chemical dependency / substance abuse) conditions as part of an overall care management program. BCBSNM has integrated behavioral health care management into our member medical care management program to provide better care management service across the health care continuum.

The Integrated Behavioral Health program includes:

- Care/Utilization Management for inpatient, outpatient and partial hospitalization and residential behavioral health care
- Condition Case Management (seven conditions)
  - Depression
  - Alcohol and substance abuse disorders
  - Anxiety and panic disorders
  - Bipolar disorders
  - Eating disorders
  - Schizophrenia and other psychotic disorders
  - Attention Deficit and Hyperactivity Disorder (ADD/ADHD)
- Intensive Case Management
- Patient Safety Program
- Focused Outpatient Management Program

Continued on next page
The table below lists the covered services under the behavioral health program.

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Applies To</th>
<th>Preauthorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Inpatient Hospital Services</td>
<td>All ages</td>
<td>Yes</td>
</tr>
<tr>
<td>Inpatient Professional Services</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Hospital Outpatient Services</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Evaluation</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Psychological Testing (Services beyond core coverage may need preauthorization)</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Assessment</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Counseling</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Therapy (Services beyond core coverage may need preauthorization)</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Comprehensive Community Support Service (Services beyond core coverage may need preauthorization)</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Telehealth Services</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Intensive Outpatient for Substance Abuse and Co-occurring Disorders</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Residential Treatment Center (RTC) (Services beyond core coverage may need preauthorization)</td>
<td>Under age 21</td>
<td>Yes</td>
</tr>
<tr>
<td>Group Home Services</td>
<td>Under age 21</td>
<td>Yes</td>
</tr>
<tr>
<td>Treatment Foster Care (Services beyond core coverage may need preauthorization)</td>
<td>Under age 21</td>
<td>Yes</td>
</tr>
<tr>
<td>Day Treatment Services</td>
<td>Under age 21</td>
<td>No</td>
</tr>
<tr>
<td>Multi-systematic Therapy</td>
<td>Under age 21</td>
<td>No</td>
</tr>
<tr>
<td>Behavioral Management Skills Development Services</td>
<td>Under age 21</td>
<td>No</td>
</tr>
<tr>
<td>School Based Counseling</td>
<td>Under age 21</td>
<td>No</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation Program (PSR)</td>
<td>Age 18 and older</td>
<td>No</td>
</tr>
</tbody>
</table>

Continued on next page
Program Overview, Continued

Behavioral Health (continued)

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Applies To</th>
<th>Preauthorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assertive Community Treatment</td>
<td>Age 21 and older</td>
<td>No</td>
</tr>
<tr>
<td>Psychiatric Emergency Room Services</td>
<td>Age 21 and older</td>
<td>No</td>
</tr>
<tr>
<td>Adaptive Skills Building (Autism)</td>
<td>All ages</td>
<td>Yes</td>
</tr>
<tr>
<td>Behavior Support Consultation</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Recovery Services</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>All Ages</td>
<td>May be required based upon the drug prescribed</td>
</tr>
</tbody>
</table>

The BCBSNM Focused Outpatient Management Program is a claims-based approach to behavioral health care management that uses data-driven analysis and clinical intelligence rules to identify members whose care and treatment may benefit from further review and collaboration. The cornerstone of this model is outreach and engagement from BCBSNM to the identified providers and members to discuss treatment plans and benefit options, to discuss the availability of additional benefits, more intensive treatments, community-based resources, and integrated care and condition management programs where appropriate. The purpose of the clinical review is to identify and address the appropriate level, intensity and duration of the outpatient treatment needed.

A detailed description of the Focused Outpatient Management Program and process is described in the Behavioral Health section of the BCBSNM Blues Provider Reference Manual.

Continued on next page
The EPSDT program is a federally mandated program ensuring comprehensive health care to Medicaid recipients from birth to 21 years of age. EPSDT is defined as:

- **Early**: Assessing health care early in life so that potential disease and disabilities can be prevented or detected in their preliminary stages, when they are most effectively treated;
- **Periodic**: Assessing a child’s health at regular recommended intervals in the child’s life to assure continued healthy development;
- **Screening**: The use of tests and procedures to determine if children being examined have conditions warranting closer medical or dental attention;
- **Diagnostic**: The determination of the nature or cause of conditions identified by the screening
- **Treatment**: The provision of services needed to control, correct or lessen health problems.

The screening segment of EPSDT is the tot to teen health check which includes the following components:

- Comprehensive health and development history* (including an assessment of both physical and behavioral health or social emotional development)
- Comprehensive unclothed physical exam*
- Appropriate immunizations, according to age and health history, unless medically contraindicated at the time*
- Laboratory tests, including an appropriate lead blood level assessment*
- Health education, including anticipatory guidance*
- Dental screening
- Vision and hearing testing

*These items must be documented in order to fulfill the requirement of an EPSDT exam and to meet HEDIS criteria. An appropriate lead blood level assessment should be completed at 12 months and 24 months.
Early & Periodic Screening, Diagnosis & Treatment (EPSDT) (continued)

<table>
<thead>
<tr>
<th>Visit Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381</td>
<td>New patient under one year</td>
</tr>
<tr>
<td>99382</td>
<td>New patient (ages 1 – 4 years)</td>
</tr>
<tr>
<td>99383</td>
<td>New patient (ages 5 – 11 years)</td>
</tr>
<tr>
<td>99384</td>
<td>New patient (ages 12 – 17 years)</td>
</tr>
<tr>
<td>99385</td>
<td>New patient (ages 18 – 39 years)</td>
</tr>
<tr>
<td>99391</td>
<td>Established patients under one year</td>
</tr>
<tr>
<td>99392</td>
<td>Established patients (ages 1 – 4 years)</td>
</tr>
<tr>
<td>99393</td>
<td>Established patients (ages 5 – 11 years)</td>
</tr>
<tr>
<td>99394</td>
<td>Established patients (ages 12 – 17 years)</td>
</tr>
<tr>
<td>99395</td>
<td>Established patients (ages 18 – 39 years)</td>
</tr>
<tr>
<td>99461</td>
<td>Initial care in other than a hospital or birthing center for normal newborn infant</td>
</tr>
</tbody>
</table>

The Centers for Medicare & Medicaid Services (CMS) has mandated that the following visit codes be used to capture all EPSDT visits:

The following CPT-4 codes must be used in conjunction with codes V20-V20.2, V20.3, V20.31 and V20.32 and/or V70.0 and/or V70.3-70.9:

- 99202-99205 New Patient
- 99213-99215 Established Patient

Screenings are encouraged based on the New Mexico Tot-to-Teen HealthCheck periodicity schedule:

- Under age 1: 6 screening/examination visits (birth, 1, 2, 4, 6, and 9 months)
- Ages 1–5: 7 screening/examination visits (12, 15, 18, and 24 months; 3, 4, and 5 years)
- Ages 6–9: two screening/examination visits (6 and 8 years)
- Ages 10–14: 4 screening/examination visits (10, 12, 13, and 14 years)
- Ages 15–18: 4 screening/examination visits (15, 16, 17, and 18 years)
- Ages 19–20: two screening/examination visits (19 and 20 years)

The established schedule must be followed unless the patient’s medical condition warrants a brief deviation.

Continued on next page
Program Overview, Continued

Early & Periodic Screening, Diagnosis & Treatment (EPSDT) (continued)

Providers can perform additional screenings at intervals other than those listed above if a patient receives care at a time not listed on the periodicity schedule, or if any components of the screen were not completed at the scheduled ages. Providers also can use additional screenings to put the patient on the periodicity schedule when possible.

The established schedule must be followed unless the patient’s medical condition warrants a brief deviation.

When a provider is seeing an ill child and a Tot-to-Teen HealthCheck is due, the provider may perform and bill for the health check as an additional service if the illness does not interfere with it.

Family Planning

Family Planning Services include but are not limited to:

- Health education and counseling necessary to make informed choices and understand contraceptive methods
- Limited history and physical examination
- Laboratory tests, if medically indicated, as part of the decision-making process for choice of contraceptive methods
- Diagnosis and treatment of sexually transmitted diseases (STDs), if medically indicated
- Screening, testing and counseling of at-risk individuals for human immunodeficiency virus (HIV) and referral for treatment
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider/practitioner
- Provision of contraceptive pills
- Provision of devices/supplies
- Tubal ligations
- Vasectomies
- Pregnancy testing and counseling

Continued on next page
Program Overview, Continued

Children with Special Health Care Needs (CSHCN)

The CSHCN program is defined as individuals less than 21 years of age, who have or are at an increased risk for a chronic physical, developmental, behavioral, neurobiological, or emotional condition, and require health and related services of a type or amount beyond that generally required by children. Examples of common diagnoses include:

- Asthma
- Diabetes
- Congenital anomalies
- Metabolic disorders
- Attention Deficit Hyperactivity Disorder (ADHD)
- Other behavioral health diagnoses
- Congenital heart disease

Individuals with Special Health Care Needs (ISHCN)

The ISHCN program is defined as individuals who have or are at an increased risk for a chronic physical, developmental, behavioral, neurobiological, or emotional condition, or have low to severe functional limitations, and require health and related services of a type or amount beyond that generally required by individuals. Examples of common diagnoses include:

- Asthma
- Diabetes
- Congenital anomalies
- Metabolic disorders
- Attention Deficit Hyperactivity Disorder (ADHD)
- Other behavioral health diagnoses
- Congenital heart disease

Native Americans

Native American Medicaid beneficiaries who meet nursing facility level of care, or who are both Medicaid and Medicare eligible, are required to enroll in Blue Cross Community Centennial to access benefits while other Native American Medicaid beneficiaries can voluntarily enroll in the program. This has been designed to address needs and concerns of Native American Medicaid beneficiaries. Native American Blue Cross Community Centennial members do not have copays.

Continued on next page
Program Overview, Continued

Newborn Enrollment

Medicaid eligible and enrolled newborns of Blue Cross Community Centennial eligible enrolled mothers are eligible for a period of 12 months starting with the month of birth. When a child is born to a mother enrolled with Blue Cross Community Centennial, a Notification of Birth (MAD Form 313) must be completed by the hospital or other Medicaid provider prior to or at the time of discharge, to ensure that Medicaid eligible newborn infants are enrolled and medically covered as soon as possible following the birth. The child will be enrolled in the same Managed Care Organization (MCO) as the enrolled mother. Do not submit claims for a newborn with the mother’s identification (ID) number.

Financial Responsibilities

Providers who participate in Blue Cross Community Centennial agree to accept the amount paid as payment in full per 42 CRF 447.15, and cannot bill a remaining balance other than copayment, coinsurance or deductible.

Providers may not bill a member for any unpaid portion of the bill or for a claim that is not paid, with the following exceptions:

- Failure to follow managed care policies: A member must be aware of the providers, pharmacies, facilities, and hospitals that are contracted with Blue Cross Community Centennial.
- The member is not eligible for the Blue Cross Community Centennial plan.
- The member has been advised by the provider that the service is not a covered benefit.
- The member has been advised by the provider that he or she is not contracted with Blue Cross Community Centennial, and has been advised of the necessity, options, estimated charges, and the option of going to a provider who is contracted with Blue Cross Community Centennial.
- The member failed to notify the provider of Blue Cross Community Centennial eligibility in a timely manner to allow the provider to meet claim filing limits.
- The member agrees in writing to have the service provided with full knowledge that he or she is financially responsible for payment.

Continued on next page
Providers may not bill a member when:
- The provider has not met the timely filing or other administrative requirements.
- Charges are denied for lack of medical necessity or not being an emergency unless the provider determined prior to rendering the service that medical necessity or emergency requirements were not met and informed the member that benefits would not be paid and the member has signed a statement to proceed with the service or item.
- The provider has been informed of the member’s eligibility or pending eligibility, the account cannot be turned over to collections or any other entity intending to collect from the member. It is the provider’s responsibility to retrieve the account turned over for collection and to accept the payment of the claim by Blue Cross Community Centennial or its selected claims processing contractor.

Personal Responsibilities:
If the member is eligible for Medicaid through the Working Disabled Individuals (WDI) program or the Children’s Health Insurance Program (CHIP), they must pay a copayment to receive certain services. If a copayment is due for these members, the copayments will be listed on their ID card as follows:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>CHIP Copayment</th>
<th>WDI Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office/Urgent Care Visit</td>
<td>$5 per visit*</td>
<td>$7 per visit*</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>$5 per visit</td>
<td>$7 per visit</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$15 per visit</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$25 per admission</td>
<td>$30 per admission</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$2 per prescription (30-day supply or 120 pills, whichever is less)</td>
<td>$5 per prescription (30-day supply or 120 pills, whichever is less)</td>
</tr>
</tbody>
</table>

* No copay for approved second opinions

Applicable copayments may be charged for missed appointments. There are no copayments for routine or preventive care, prenatal care, or family planning, or for Native Americans.
### Program Overview, Continued

<table>
<thead>
<tr>
<th>Provider Satisfaction Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBSNM will conduct an annual Provider Satisfaction Survey for Blue Cross Community Centennial providers following NCQA guidelines and provide the results in an annual report to the New Mexico Human Services Department (HSD) and the Medical Assistance Division (MAD). Summary results are also published in the Blue Review provider newsletter and on the provider website at bcbsnm.com.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children Health Insurance Program as provided through CHIP Re-authorization Act (CHIPRA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children eligible for category 071 with a family income between 185-235% of poverty will have copayment requirements. There are no copayments required during presumptive eligibility or retroactive eligibility periods.</td>
</tr>
<tr>
<td>Applicable copayments are included on the members’ identification card.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Working Disabled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults who qualify for Medicaid, are employed, and are considered disabled, have a copayment that is consistent with the CHIP program under category 074.</td>
</tr>
<tr>
<td>- It is the responsibility of the provider to collect any applicable copayments.</td>
</tr>
<tr>
<td>- It is the responsibility of the family to track and total the copayments paid. The family has to provide the Medical Assistance Division (MAD) verification that the copayment maximum has been paid.</td>
</tr>
<tr>
<td>- Copayment maximums are calculated at initial determination of eligibility by the Income Support Division (ISD).</td>
</tr>
<tr>
<td>There is a copayment requirement for a missed appointment. Based on standard provider practice, a member may be billed for cancellation of an appointment without adequate notice.</td>
</tr>
</tbody>
</table>
Claims

ID Cards & Verification of Coverage

Each member receives an ID card containing the member’s name, ID number, and information about his or her benefits.

At each office visit, your office staff should:
- Ask for the member’s ID card,
- Copy both sides of the ID card and keep the copy with the patient’s file, and
- Determine if the member is covered by another health plan and record information for coordination of benefits purposes. If the member is covered by another health plan, the provider must submit to the other carrier(s) first. After the other carrier(s) pay, submit the claim to BCBSNM.

Refer to the member’s ID card for the appropriate telephone number to verify eligibility and applicable copayments specific to the member’s coverage. (Native American’s are exempt from copayment amounts.)

Sample of ID Card

Front of card

Back of card

Continued on next page
Participating providers are strongly encouraged to submit claims within 90 days of the date of service, using the standard CMS-1500 or UB-04 claim form or electronically as discussed below. Services billed beyond 180 days from the date of service are not eligible for reimbursement. These providers may not seek payment from the member. Indian Health Service providers have up to 2 years from the date of service to file claims.

To expedite claims payment, the following information must be submitted on all claims:

- Member’s name, date of birth and gender
- Member’s ID number (as shown on the member’s ID card, including the 3-digit alpha prefix: YIF)
- Individual member’s group number, where applicable
- Indication of: 1) job-related injury or illness, or 2) accident-related illness or injury, including pertinent details
- ICD-9 diagnosis codes
- NDC codes in accordance with Medicaid requirements
- Date(s) of service(s)
- Charge for each service
- Provider’s Tax Identification Number (TIN)
- Provider NPI number (Type 1 and Type 2 if applicable)
- Name and address of participating provider
- Signature of participating provider providing services
- Place of service code
- Preauthorization number, if required
- The electronic payer ID # for participating providers is 00790.

Claims containing substantially all the required data elements necessary for accurate adjudication (“clean claim”) without the need for additional information pay within 30 calendar days of receipt.

Duplicate claims may not be submitted prior to the applicable 30-day claims payment period.

As a condition of the capitation payment, providers with a sub-capitated reimbursement arrangement are required to submit all utilization or encounter data in the same standards of completeness and accuracy as outlined above. This allows proper adjudication of claims to include fee-for-service Medicare claims.
Claims, Continued

Submitting Claims

Claims should be submitted electronically through Availity™ Health Information Network for processing. For information on electronic filing of claims, contact Availity at 1-800-282-4548.

BCBSNM will process electronic claims consistent with the requirements for standard transactions set forth in 45 CFR Part 162. Any electronic claims submitted to BCSBNM should comply with those requirements.

BCBSNM will reimburse family planning clinics, School-Based Health Centers, and Department of Health public health clinics for oral contraceptive agents and Plan B when dispensed to members and billed using HCPCS codes and CMS-1500 forms.

Paper claims must be submitted on the CMS-1500 (Physician/ Professional Provider) or CMS-1450 (UB-04 Facility) claim form to:

Medicaid
P.O. Box 27838
Albuquerque, NM 87125-7838

Self-directed providers community benefit claim submittals:

BCBSNM together with the other MCO’s will contract with a vendor to implement an electronic visit verification system to monitor member receipt and utilization of the Community Benefit for Blue Cross Community Centennial. Claims from self-directed providers should be submitted initially to the Fiscal Management Agency (FMA). The FMA will then send claims information to BCBSNM.

• Members must review and approve timesheets of their providers to determine accuracy and appropriateness.
• No Self-Directed Community Benefit provider shall exceed 40 hours paid work in a consecutive 7 calendar day period.
• Timesheets must be submitted and processed on a two-week pay schedule according to HSD’s prescribed payroll payment schedule.
• The FMA is responsible for processing payments for approved Blue Cross Community Centennial services and goods.
• BCBSNM reimburses the FMA for authorized Self-Directed Community Benefit services provided by providers at the appropriate rate for self-directed Home and Community Based Services (HCBS), which includes applicable payroll taxes.

Continued on next page
Nursing Facility Billing Requirements

The Human Services Department (HSD) has standardized the Nursing Facility (NF) billing requirements for all Medicaid payers. Please bill these services on the UB-04 form with the codes outlined below.

**Revenue Codes:**
Bill with the following revenue codes for the services listed.

- **0182** – Home Visit or Discharge Reserve Bed Day (to allow for accurate calculation and limitation of these reserve bed days)
- **0185** – Inpatient Hospital Reserve Bed Day
- **0190** – Subacute Care Long Term Care Services – Nursing Facility
- **0199** – High Nursing Facility Level of Care

**Value Codes:**
Value code 23 (patient estimated responsibility) should be billed to indicate the Medical Care Credit (MCC) for each recipient.

Non-covered reserve bed days must be billed as value code 80 for non-covered days. Non-covered days plus covered days, billed as value code 81, must equal total days.

**Patient Discharge Status:**
Use the appropriate patient discharge status code to indicate the recipient’s status on the last day of the period for which payment is requested.

When using the discharge status code 30 (still a patient) the TO date of service is counted in the days billed.

For more information, refer to: NMCPR-NMAC-Chapter 312 - Long term care services - nursing services, Part 2 - nursing facilities

Continued on next page
Coordination of Benefits

If a member has coverage with another plan or Medicare that is primary to Medicaid, submit a claim for payment to that plan first. The amount payable by Blue Cross Community Centennial will be governed by the amount paid by the primary plan and Medicaid secondary payer law and policies. As specified in New Mexico Medicaid guidelines, Blue Cross Community Centennial is the payer of last resort for Blue Cross Community Centennial members. Claims must be submitted within 180 days from the other insurance paid date.

When submitting claims for members for which Blue Cross Community Centennial is not the primary insurance, attach a copy of the primary payer’s EOB with the exception of services billed by Early, Periodic Screening, and Diagnostic Treatment (EPSDT), pregnancy and prenatal care. The primary payer’s EOB must match the submitted claim so that charges can be appropriately processed.

Billing for Non-covered Services

Providers may not bill a member for a non-covered service unless:

- you have informed the member in advance that the service is not covered,
- the member is informed by a participating provider of the necessity, options, and charges for the services, and the option of going to another participating provider who is a Medicaid provider, and
- the member has agreed in writing to pay for the services if they are not covered.

Billing Audits

BCSNM will conduct both announced and unannounced site visits and field audits to contracted providers defined as high risk (providers with cycle/auto billing activities, providers offering DME, home health, behavioral health, and transportation services) to ensure services are rendered and billed correctly.

Continued on next page
Claims, Continued

Hold Member Harmless

Participating providers and any sub-contractors of providers agree that in no event, including but not limited to non-payment by the Corporation, insolvency of the Corporation, or breach of signed Agreement, shall participating providers bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a member to whom health care services have been provided, or person acting on behalf of the member for health care services provided.

Participating providers shall not be prohibited from collecting any outstanding deductible, coinsurance, or copayment, if applicable, or collection of payment for non-covered services from the member. Remaining balances shall be treated as contractual adjustments by participating providers and shall not be billed to the member. Members may not be charged for any unpaid portion of the bill or for a claim that is not paid because of a provider administrative error or failure.

Encounter Reporting

BCBSNM is required by New Mexico Human Services Department (HSD) to report all services rendered to Blue Cross Community Centennial members. The reporting of these services, also known as encounter data reporting, is an extremely critical element to the success of Blue Cross Community Centennial.

HSD uses encounter data reporting to evaluate health plan compliance on many vital issues. Regardless of whether the service you provide is capitated or fee-for-service, claims should be submitted to BCBSNM within 20 days of the date of service to accommodate the State of New Mexico’s request for timely encounter data. Blue Cross Community Centennial is required to submit encounter data to the State of New Mexico within 30 days. This would also include claims for which you expect no reimbursement from BCBSNM because another payer has already paid the claim in full.

Provider Claim Summary

Provider Claim Summaries (PCSs) for Blue Cross Community Centennial are generated no differently than our other lines of business. The member’s share is calculated based on the type of service, benefits, etc. The Explanation of Benefits (EOB) will not be sent to members for the Blue Cross Community Centennial line of business.
Claims, Continued

Claim Disputes

You may dispute a claims payment decision by requesting a claim review. If you have questions regarding claims appeals, please contact the BCBSNM Provider Customer Service Department at the number listed on the Key Contacts page. Claims returned as a dispute or with additional information must be returned to BCBSNM within 30 days of receipt. If corrected claims are not resubmitted within 30 days, there is a risk of being denied for timely filing if the original date of service is greater than 180 days.

If a claim is suspended due to a credible allegation of fraud and it is deemed that the payment can eventually be sent to the provider, BCBSNM is not responsible for interest payment.

Deficit Reduction Act

In an effort to deter and prevent waste and abuse, health care entities who receive or pay out at least $5 million in Medicaid funds per year must now comply with the Deficit Reduction Act (DRA) Section 6032, Employee Education about False Claims Recovery.

Participating providers must establish written policies for all employees, including management, providing detailed information about false claims, false statements, and whistleblower protections under applicable federal and state abuse laws. These written policies must include a specific discussion of the applicable laws and detailed information regarding the detection and prevention of waste and abuse, as well as the rights of employees to be protected as whistleblowers. The provider shall include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers, and a specific discussion of the provider/subcontractor’s policies and procedures for detecting and preventing waste and abuse.

For more information on reporting fraud and abuse, please see Section 18 of the Blues Provider Reference Manual. Additionally, the Special Investigations Department maintains a 24-hour fraud hotline, through which you can report any suspicions of fraud. All calls are confidential, and you may report your information anonymously. To file a report, call the hotline at 1-877-272-9741 or go to www.bcbsnm.com/sid/reporting.
Reimbursement Methodologies

Overview
The Blues Provider Reference Manual plus this section, explain the provider payment policies. The following is a description of the basic reimbursement methodologies used to reimburse providers. BCBSNM bases provider reimbursement, for medically necessary services, on the HSD fee schedule and reimbursement methods. The reimbursement values are updated as HSD makes their updates.

Professional Reimbursement Methodology

Fee Schedule
This reimbursement method is tied to the filing of a CMS-1500 claim form for services provided as designated by CPT or HCPCS codes.

The BCBSNM fee schedule is based on the Medicaid Fee Schedule using CPT and HCPCS codes.

BCBSNM updates the provider fee schedule as HSD makes revisions to the Medicaid fee schedule and notifies BCBSNM of those updates.

Fee Schedule Requests
Providers can obtain an entire fee schedule or request fee information for specific codes by filling out a Fee Schedule Request Form available on the bcbsnm.com provider website under Forms.

Note: The BCBSNM fee schedule is not a guarantee of payment. Services represented are subject to provisions of the health plan including, but not limited to: membership, eligibility, claim payment logic, provider contract terms and conditions, applicable medical policy, benefits limitations and exclusions, bundling logic, and licensing scope of practice limitations. Maximum allowable may change from time to time subject to notice requirements of applicable law and regulations and prevailing provider agreement. Additional provider information is available on the website at www.bcbsnm.com.

Continued on next page
Reimbursement Methodologies, Continued

**Out of Network Payment**

When an out-of-network provider submits a request for routine services, BCBSNM determines if the service is medically necessary and if the member can receive the same service in-network. If we determine that the service is medically necessary, but is not available in-network, the Utilization Review (UR) staff works with Provider Contracting to develop a single-case agreement to ensure that the provider will accept the New Mexico Medicaid rate and will not balance bill the member. BCBSNM enters the authorization into the medical management platform for claims payment and documentation of clinical rationale for approval.

Except as otherwise precluded by law and/or specified for I/T/Us, Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC), family planning providers, and emergency services providers, BCBSNM reimburses non-contracted providers 95% of the Medicaid fee schedule rate for the covered services provided.

**FQHC and RHCs**

BCBSNM shall reimburse both contracted and non-contracted FQHCs and RHCs at a minimum of the Prospective Payment System (PPS) or alternative payment methodology in compliance with Section 1905(a)(2)(C) of the 1902 Social Security Act.

The following guidelines may be helpful in billing these services.

**Federally Qualified Health Clinics**

- The PPS rate includes all practitioner services, pharmacy, lab, radiology, behavior health and dental services that take place at the FQHC. (Dental claims must be billed to DentaQuest.)
- A clinic administratively associated with an FQHC is only reimbursed at the FQHC encounter rate if that clinic is actually part of the certified FQHC.
- An FQHC cannot have separate provider numbers for professional, dental, pharmacy, or behavioral health claims. An FQHC should not have separate provider numbers for pharmacy, physician or dental services. A separate pharmacy claim is not billed or reimbursed; the encounter rate is inclusive of dispensing the drug items from the FQHC.
Reimbursement Methodologies, Continued

FQHC and RHCs (continued)

- The encounter will be paid:
  - when the recipient sees a practitioner at the FQHC,
  - when the practitioner makes an inpatient hospital visit or goes to a nursing facility, or
  - when the practitioner renders a service at a hospital such as delivering a baby.
- FQHC must bill on a UB-04 claim form with type of bill 771.
- FQHC must bill the Managed Care Organization (MCO) for the revenue codes and procedure codes on the UB-04 form, listing all the services provided at the encounter, and the MCO should pay the single encounter rate. Listing the procedure codes is very important. Payment is made at the FQHC encounter rate.
- Only if the FQHC cannot bill that way, should an FQHC use the revenue code of 0529 for a physical health or dental service, and revenue code 0919 for a behavioral health service.

Free-Standing Rural Health Clinics
- The revenue code for free-standing health clinics is 0521. The provider should also include the primary procedure code.
- Unlike an FQHC, free-standing or hospital-based RHC can have a separate provider number for pharmacy and for dental services that are paid just like other pharmacies and dentists.

Hospital-Based Rural Health Clinics
- In fee-for-service Medicaid, a hospital based RHC bills revenue code 0510, an outpatient clinic visit, but they can also bill other services at that visit such as laboratory with appropriate revenue codes. FFS pays the hospital-based RHC at a percent of billed charges.
- MCOs pay the set encounter rate to a hospital-based RHC (HB-RHC). The HB-RHC should bill all revenue codes along with a procedure code. The MCO pays the encounter rate on the 0510 revenue code, similar to what is being done with FQHCs.

Continued on next page
### Reimbursement Methodologies, Continued

<table>
<thead>
<tr>
<th>Indian Health Services (IHS), Tribes and Tribal Organizations and Urban Indian Organizations (I/T/U)</th>
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<tbody>
<tr>
<td>BCBSNM reimburses both contracted and non-contracted provider I/T/Us at a minimum of 100% of the rate currently established for the IHS facilities or federally leased facilities by the Office of Management and Budget (OMB). If a rate is not established by OMB for a particular service, then reimbursement shall be at an amount not less than the Medicaid fee schedule. Services provided within I/T/Us are not subject to prior authorization requirements.</td>
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<tr>
<th>Family Planning Non-Contract Providers</th>
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<tbody>
<tr>
<td>BCBSNM shall reimburse family planning non-contracted providers for the provision of services to members at a rate set by HSD.</td>
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<tr>
<th>Pharmacies</th>
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<tr>
<td>BCBSNM pays a dispensing fee consistent with NMSA 1978, Section 27-2-16 for each covered prescribed drug when drug product selection is performed under NMSA 1978, Section 26-3-3.</td>
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<tr>
<th>Pregnancy Termination</th>
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<tr>
<td>BCBSNM pays claims submitted by qualified and credentialed providers for state and federally approved pregnancy termination procedures rendered to eligible members.</td>
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<tr>
<th>Reimbursement for Members Who Disenroll While Hospitalized</th>
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<tr>
<td>If a member is hospitalized at the time of enrollment or disenrollment from an MCO or upon an approved switch from one MCO to another, the originating MCO is responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospital as designated by the New Mexico Department of Health until the date of discharge. Upon discharge, the member becomes the financial responsibility of the MCO receiving capitation payments.</td>
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<tr>
<td>BCBSNM is not responsible for payment of any covered services incurred by members transferred to BCBSNM prior to the effective date of transfer.</td>
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Emergency Services

Emergency services are available to members 24 hours-a-day, 7 days-a-week. Any provider of emergency services that is a non-contracted provider must accept, as payment in full, no more than the amount established by HSD for such services. This rule applies whether or not the non-contracted provider is within the state.

BCBSNM reimburses acute general hospitals for emergency services, which they are required to provide because of federal mandates such as the “anti-dumping” law in the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239 and 42 U.S.C. § 1395(dd), and section 1867 of the Social Security Act.

BCBSNM pays for both the services involved in the screening examination and the services required to stabilize the member, if the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists. BCBSNM may not refuse to cover emergency services based on an emergency room provider, hospital or fiscal agent not notifying the member’s PCP or BCBSNM of the member’s screening and treatment within 10 calendar days of presentation for emergency services. If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, BCBSNM will pay for both the services involved in the screening examination and the services required to stabilize the member. The member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

BCBSNM pays for all emergency services and post-stabilization care that are medically necessary services until the emergency medical condition is stabilized and maintained.

If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, then the determining factor for payment liability is whether the member had acute symptoms of sufficient severity at the time of presentation. In these cases, BCBSNM will review the presenting symptoms of the member and pay for all services involved in the screening examination where the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard.
Emergency Services (continued)

BCBSNM may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. If the member believes that a claim for emergency services has been inappropriately denied by BCBSNM, the member may seek recourse through the Appeal and Fair Hearing process.

Emergency and Post-Stabilization Services

BCBSNM is financially responsible for post-stabilization services obtained within or outside BCBSNM’s provider network that are pre-approved by BCBSNM. BCBSNM’s financial responsibility for post-stabilization services that have not been pre-approved shall end when: (i) a contracted provider with privileges at the treating hospital assumes responsibility for the member’s care; (ii) a contracted provider assumes responsibility for the member’s care through transfer; (iii) a representative of BCBSNM and the treating physician reach an agreement concerning the member’s care; or (iv) the member is discharged.

BCBSNM reviews and approves or disapproves Claims for Emergency Services based on the definition of Emergency Medical Condition. BCBSNM bases coverage decisions for emergency services on the severity of symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. BCBSNM does not impose restrictions on the coverage of emergency services that are more restrictive than those permitted by the prudent layperson standard.

BCBSNM provides coverage for inpatient and outpatient emergency services, furnished by a qualified provider, regardless of whether the member obtains the services from a contracted provider, that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard. These services are provided without prior authorization in accordance with 42 C.F.R. § 438.114. BCBSNM does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

Continued on next page
Reimbursement Methodologies, Continued

**Timely Payments to All Providers**

BCBSNM and any of its subcontractors shall make timely payments to both its contracted and non-contracted providers as defined below. BCBSNM and any of its subcontractors or providers paying their own claims are required to maintain claims processing capabilities to comply with all state and federal regulations.

For claims from I/T/Us, day activity providers, assisted living providers, nursing facilities and home care agencies including community benefit providers, 95% of clean claims must be adjudicated within a time period of no greater than 15 calendar days of receipt and 99% or more of clean claims must be adjudicated within a time period of no greater than 30 calendar days of receipt;

For all other claims, 90% of all clean claims must be adjudicated within 30 calendar days of receipt, and 99% of all clean claims must be adjudicated within 90 calendar days of receipt.

BCBSNM pays interest at the rate of 2% for each month or portion of any month on a prorated basis on the amount of a clean claim electronically submitted by a contracted provider and not adjudicated within 14 calendar days.

BCBSNM pays interest at the rate of 2% for each month or portion of any month on a prorated basis on the amount of a clean claim manually submitted by a contracted provider and not adjudicated within 45 calendar days of the date of receipt;

BCBSNM accepts from providers and subcontractors only national HIPAA-compliant standard codes and editing to ensure that the standard measure of units is billed and paid for.

BCBSNM reviews claims to ensure that services being billed are provided by providers licensed to render these services, that services are appropriate in scope and amount, that members are eligible to receive the services, and that services are billed in a manner consistent with HSD defined editing criteria and national coding standards.

BCBSNM will not deny services for a member's failure to pay any copayment amounts. BCBSNM will not impose any copayment requirements on any Native American.

Continued on next page
Reimbursement Methodologies, Continued

**General Payment Policies for All Providers**

BCBSNM will not reduce payments to hospitals or emergency rooms for any member non-emergent visits to the emergency room.

BCBSNM will not make payment to any provider who has been barred from participation based on existing Medicare, Medicaid or SCHIP sanctions, except for emergency services.

Contracted providers will accept payment or appropriate denial made by BCBSNM (or, if applicable, payment by BCBSNM that is supplementary to the member’s third party payer) plus the amount of any applicable member cost sharing responsibilities, as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the member in excess of the amount of applicable cost sharing responsibilities.

If a member is in a nursing facility at the time of disenrollment (not including loss of Medicaid eligibility), BCBSNM will be responsible for the payment of all covered services until the date of discharge or the date of disenrollment, whichever occurs first.

BCBSNM participates in Payment Reform Projects to begin the process of recognizing and rewarding providers based on outcomes, rather than the volume of services delivered. In addition to those projects outlined below, BCBSNM has the option to develop other pay for performance initiatives for physical health, behavioral health and long-term care with the approval of HSD.

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**Gross Receipts Tax**

BCBSNM will reimburse Gross Receipts Tax (GRT) to applicable providers who meet the following criteria:

- The organization is a for-profit entity; and
- The organization is required to pay GRT to the State of New Mexico; and
- The organization completes the CRS-1 form and submits the CRS-1 number to BCBSNM.

Rates above 100% of the Medicaid fee schedule are inclusive of GRT.

Continued on next page
Reimbursement Methodologies, Continued

The current HSD general expectations and directed initiatives are:

- Ambulatory treatment of adult diabetes and pediatric asthma
- Specific requirements for Adult Diabetes Project
  - The adult diabetes project includes a provider or a consortium of providers that serve the Native American population. The providers may include I/T/Us and/or FQHCs.
- There will be a project focused on bundled payments for hospital care and follow-up of members with diagnoses of pneumonia and congestive heart failure.
- BCBSNM participates in the required HSD collaborative approach in the development of the payment reform projects among all Blue Cross Community Centennial MCOs. BCBSNM also collaborates with other entities, including: (i) the New Mexico Hospital Association; (ii) the New Mexico Primary Care Association; (iii) the New Mexico Medical Society; (iv) the Albuquerque Coalition for Health Care Quality (AC4HCQ); and (v) I/T/Us.
- BCBSNM, in collaboration with the other Blue Cross Community Centennial MCOs and the aforementioned partners, will develop a project model that will be subject to approval by HSD and that will include:
  - Development of baseline data and evaluation methodology;
  - Definition of best practices in managing the project populations;
  - Development of performance measures; and
  - Development of provider incentives to reduce unnecessary utilization and improve patient outcomes.
- All decisions about the goals and the design of the payment reform pilots are subject to final approval by HSD, including:
  - Minimum requirements for provider participation;
  - Program goals;
  - Clinical measures;
  - Provider incentives, including gain-sharing/shared savings arrangements between the MCOs and providers; and
  - Establishment of a common methodology for measurement and evaluation.
- Specific Requirements for bundled rates for Inpatient Hospital Admissions Project:
  - BCBSNM will develop a bundled rate that will cover the cost of an initial hospital stay and 30 calendar days post-discharge for (i) pneumonia and (ii) congestive heart failure.
Reimbursement Methodologies, Continued

Payment Reform Projects
(continued)

- The rate to be developed for these projects shall include the following services:
  - initial hospital admission
  - any subsequent re-admissions to the same facility for the same diagnosis within a 30 calendar day period
  - office visits with the patient’s PCMH
  - emergency room visits for the same diagnosis
  - diagnostic tests
  - in-home services
  - wellness and community health

Member Cost-Sharing

As part of personal responsibility, members are expected to pay a copayment for services received. Please note the only exception applies to Native American members who are not required to pay a copayment.

In accordance with federal regulations for individuals over 100% of the federal poverty level, individuals who use emergency room facilities/services for non-emergency care may be charged a copayment. BCBNM will not reduce payments to hospitals or emergency rooms for any member non-emergent visits to the emergency room.

Copays and the use of a legend drugs:

- Members who receive a legend drug when a therapeutically equivalent generic drug is available will be required to pay a copayment if they are over 100% of the federal poverty level, per federal regulation. Native Americans are exempt from paying copayments for medications.
- For legend drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions, copayments do not apply. This rule is applicable to all Blue Cross Community Centennial members.
- BCBSNM has a copayment exception process for other legend drugs where such drugs are not tolerated by the member.

A provider may use legal action to collect a copayment from a member; however, providers may not deny services for a member’s failure to pay the copayment amount.
Health Care Management

Quality Improvement Program

Quality improvement is an essential element in the delivery of care and services to members. To define and assist in monitoring quality improvement, the Blue Cross Community Centennial Quality Improvement Program focuses on measurement of clinical care and service delivered by participating providers against established goals. The Quality Improvement Program is described in the Quality Improvement section of the BCBSNM Blues Provider Reference Manual.

Utilization Management Program

The Utilization Management (UM) program includes:

- Prospective review (preauthorization and precertification)
- Concurrent review
- Discharge planning
- Retrospective review

The Utilization Management Program is described in the Utilization Management, Case Management, and Condition & Lifestyle Management section of the BCBSNM Blues Provider Reference Manual.

Individual Case Management

BCBSNM nurses and clinicians provide individual Complex Case Management for members with chronic, complex, or catastrophic conditions. Complex Case Management activities are based on national standards of practice from the Case Management Society of America. All BCBSNM case managers are certified or are working toward taking the certification examination. Complex Case Management activities supplement care coordination activities when a member has a complex issue requiring, for example, care from an out-of-state center of excellence. Examples of member conditions that would warrant this assistance would be transplants, congenital heart surgery, fetal surgery, etc. The case manager will assist the care coordinator with arranging for the out of state transportation, evaluation, and treatment.


Continued on next page
Health Care Management, Continued

Referrals

Referral Guidelines
- PCPs do not need to notify BCBSNM for referrals to contracted (in-network) specialists.
- Preauthorization is required from BCBSNM for services to non-contracted (out-of-network) specialists before the services are rendered.
- Services rendered to members by non-contracted providers without appropriate medical referrals or preauthorizations will not be considered for reimbursement, or will be processed at a lower benefit level for the member.

Obstetrical/Gynecological Services
Female members can self-refer to contracted providers for routine OB/GYN services.

Family Planning Services
Members can self-refer to contracted and non-contracted family planning providers in the State of New Mexico. Family planning providers include PCPs, OB/GYNs, Planned Parenthood clinics, and Department of Health clinics.

Out–of-State Medical Services
Out-of-state (non-border) medical services are not a Blue Cross Community Centennial covered benefit if the service is available in-state.

Behavioral Health Referrals

If you have Blue Cross Community Centennial patients who need behavioral health services, please contact the BCBSNM behavioral health team at 1-800-693-0663 after documenting that the patient has given his or her permission to receive the services.

Behavioral health referrals may be routine, urgent, or emergent and should be addressed as quickly as clinically indicated. If a member is in an emergency situation (e.g. actively suicidal), the provider may determine it is clinically indicated to call 911 or have an escort to an emergency services location.

Continued on next page
The following are common indicators for a referral to BCBSNM behavioral health team for information regarding behavioral health services or for a referral directly to a behavioral health provider by a PCP:

- suicidal or homicidal ideation or behavior
- at-risk of hospitalization due to a behavioral health condition
- children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital, residential treatment facility, or treatment foster care placement
- trauma victims, including possible abuse or neglect
- serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment, mental retardation, or other developmental disabilities
- request by member or a representative for behavioral health services
- clinical status that suggests the need for behavioral health services
- identified psychosocial stressors and precipitants
- treatment compliance complicated by behavioral characteristics
- behavioral, psychiatric or substance abuse factors influencing a medical condition
- victims or perpetrators of abuse and/or neglect and members suspected of being subject to abuse and/or neglect
- non-medical management of substance abuse
- follow-up to medical detoxification
- an initial PCP contact or routine physical examination indicates a substance abuse or mental health problem
- prenatal visit indicates a substance abuse or mental health problem
- positive response to questions or observation of clinical indicators or laboratory values that indicate substance abuse
- a pattern of inappropriate use of medical, surgical, trauma, urgent care or emergency room services that could be related to substance abuse or other behavioral health conditions
- the persistence of serious functional impairment

Additionally, if a PCP would like to consult a psychiatrist or other behavioral health clinician with prescriptive authority in the use of psychopharmacotherapy and diagnostic evaluations, the PCP can contact either the BCBSNM Provider Service Unit or the Behavioral Health Team at 888-349-3706 directly for assistance.
Health Care Management, Continued

Preauthorization

Unless otherwise prohibited by law, preauthorizations, also referred to as prior authorization, prior approval or certification, are required for certain services before they are rendered. Authorizations are based on benefits as well as medical necessity, which are supported through clinical information supplied by requesting physicians. Preauthorizations can be obtained by calling the BCBSNM Medicaid program number at 1-877-232-5518.

**Note:** Medical necessity must be determined before an authorization number will be issued. Claims received that do not have a preauthorization number will be denied. Providers may not seek payment from the member when a claim is denied for lack of a preauthorization number.

<table>
<thead>
<tr>
<th>Services Requiring Preauthorization</th>
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<tbody>
<tr>
<td>Abdominoplasty</td>
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<tr>
<td>Acute care facility regardless of condition/diagnosis</td>
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<tr>
<td>Acute hospital care</td>
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<tr>
<td>Adaptive skills building (autism)</td>
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<tr>
<td>Adenoidectomy</td>
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<tr>
<td>Adult chemical dependency residential treatment center (RTC) services</td>
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<tr>
<td>Adult day care – S5100</td>
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<tr>
<td>Advertisement reimbursement fee – G9012</td>
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<tr>
<td>Air ambulance</td>
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<tr>
<td>Anesthesia for dental work</td>
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<tr>
<td>Assisted living – T2031</td>
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<tr>
<td>Baby diapers – T4529 and T4530</td>
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<tr>
<td>Behavioral health &amp; chemical dependency – inpatient facility</td>
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<tr>
<td>Blepharoplasty</td>
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<tr>
<td>Breast pump, electric (ac and/or dc), any type – E0603</td>
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<tr>
<td>Breast pump, hospital grade, electric (ac and/or dc), any type – E0604</td>
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<tr>
<td>Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders – M0064</td>
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<tr>
<td>Bunionectomy</td>
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<tr>
<td>Cardiac rehabilitation</td>
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<tr>
<td>Carpal tunnel</td>
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<td>CAT scans</td>
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**Preauthorization (continued)**

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<tr>
<th>Service</th>
<th>Code</th>
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<tr>
<td>Cholecystectomy</td>
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<tr>
<td>Cleft lip &amp; palate repair</td>
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<tr>
<td>Community transition goods – T1999</td>
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<tr>
<td>Consumer directed training – S5110</td>
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<tr>
<td>Coordinated home care</td>
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<tr>
<td>Copay when a therapeutically equivalent generic drug is available, except drugs that are classified as psychotropic for the treatment of behavioral health conditions</td>
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<tr>
<td>Cosmetic procedures</td>
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<td>CT scans</td>
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<td>CTA scans</td>
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<td>Dental varnish – D1206</td>
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<tr>
<td>Diabetes equipment copay</td>
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<tr>
<td>Diabetes supplies - needles, syringes, swabs, and lancets – if separate Rx benefit, diabetes supplies covered under Rx</td>
<td></td>
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<tr>
<td>Diapers, incontinent garments by DME Provider</td>
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<td>Disposable underpads &quot;Chux&quot; by DME Provider</td>
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<tr>
<td>Early childhood evaluation program (ECEP)</td>
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<tr>
<td>Electroconvulsive therapy (ECT) – 00104 and 90870</td>
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<tr>
<td>Emergency response (monthly fee) – S5161</td>
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<tr>
<td>Emergency response (testing and maintenance) – S5160</td>
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<tr>
<td>Employment supports (including job coach) – T2019</td>
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<tr>
<td>Environmental modifications – S5165</td>
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<tr>
<td>Extended and skilled nursing facilities</td>
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<tr>
<td>Extended lodging for homeless members – A0180</td>
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<tr>
<td>Foster care, therapeutic, child; per diem</td>
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<td>Foster care, therapeutic, child; per diem – S5145</td>
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<tr>
<td>Genetic testing and/or counseling</td>
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<tr>
<td>Group home services</td>
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<td>Hearing aid device, evaluation and ear mold</td>
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<tr>
<td>Holter monitor</td>
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<td>Home health aide – S9122</td>
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<td>Home infusion</td>
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<td>Home life day activity – 99509</td>
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<td>Homemaker</td>
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<td>Hospice</td>
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### Health Care Management, Continued

**Preauthorization (continued)**

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<tr>
<th>Service Description</th>
<th>Revenue Codes</th>
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<tr>
<td>Hysterectomy</td>
<td>E0700</td>
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<tr>
<td>Infant car seats – E0700</td>
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<tr>
<td>Infant mental health program – 90791, 90832, 90834, 90837</td>
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<tr>
<td>Infertility related services</td>
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<td>Infertility testing</td>
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<td>Injectable medication</td>
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<tr>
<td>Inpatient detox at nonhospital-based facilities – following revenue codes: 0116, 0126, 0136, 0146, 0156, 0204</td>
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<tr>
<td>Intercellular fluid/main immunogenic region–related to oncology (ICF/MR)</td>
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<tr>
<td>Institutional respite – H0045</td>
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<tr>
<td>Intradiscal electrothermic therapy (IDET)</td>
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<tr>
<td>Insulin pump</td>
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<td>Intravenous (IV) outpatient services</td>
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<tr>
<td>Kyphoplasty</td>
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<td>Monitoring / changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders</td>
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<td>MRA scans</td>
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<tr>
<td>MRI of the breast</td>
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<td>MRI scans</td>
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<tr>
<td>MRS scans</td>
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<tr>
<td>Nuclear cardiology</td>
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<td>Nutritional supplements – B4149 through B4162</td>
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<td>Occupational therapy – G0152</td>
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<tr>
<td>Oral surgery</td>
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<td>Orthotics, functional</td>
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<td>Other oral surgery covered under medical plan</td>
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<td>Pain management procedures and devices</td>
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<td>Personal care/self-care</td>
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<td>PET scans</td>
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<td>Physical therapy – G0151</td>
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<tr>
<td>Physician &amp; nurse visits</td>
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<td>Portable cribs – E0300</td>
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<td>Pre-Allocation emergency response – T1023</td>
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<td>Pregnancy terminations</td>
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*Continued on next page*
Preauthorization (continued)

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<tr>
<th>Service Description</th>
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<tr>
<td>Private duty nursing – LPN=T1003, RN=T1002</td>
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<tr>
<td>Prosthetics</td>
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<tr>
<td>Prosthetics; breast prosthetics</td>
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<td>Provider assessment – T1028</td>
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<tr>
<td>Psychiatric inpatient hospital services</td>
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<td>Pulmonary rehabilitation – Limit: none</td>
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<td>Reconstructive surgical procedures for the breast</td>
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<tr>
<td>Renal dialysis</td>
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<td>Residential treatment center (RTC) under age 21</td>
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<tr>
<td>Respite care –, H0045, S5151, S5190, S9125, T1005</td>
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<td>Rhinoplasty</td>
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<td>Sclerotherapy</td>
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<td>Septoplasty</td>
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<td>Sleep studies</td>
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<td>Special procedures</td>
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<td>Speech therapy – G0153</td>
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<td>Sterilization</td>
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<td>Subacute care residential treatment</td>
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<td>Telehealth originating site facility fee – Q3014</td>
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<tr>
<td>Tonsillectomy</td>
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<td>Traditional medicine benefit – S9445 and T5999</td>
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<td>Transitional living for chemically dependent/psychiatrically impaired adults and children – H0011, H0017, H0018</td>
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<tr>
<td>Transplant: bone marrow</td>
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<tr>
<td>Transplant: corneal transplants</td>
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<td>Transplant: heart</td>
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<td>Transplant: heart/lung</td>
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<td>Transplant: kidney</td>
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<td>Transplant: liver</td>
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<td>Transplant: lung</td>
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<td>Transplant: pancreas</td>
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<tr>
<td>Uvulopalatopharyngoplasty</td>
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<td>Uvulopharyngopalatoplasty</td>
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<tr>
<td>Varicose veins – surgery, treatment</td>
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<tr>
<td>Vertebroplasty</td>
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</tbody>
</table>
Health Care Management, Continued

Timeliness of Decisions & Notifications

The table below describes the timelines needed for review of routine and urgent preauthorization.

| Routine Preauthorization | Decision – To be rendered within 14 calendar days from receipt of request for services  
|                         | Durable Medical Equipment (DME) – Decision to be rendered within 7 working days.  
|                         | Notification – Provider shall be notified within one working day of making decision for authorization or denial of non-urgent (routine) care  
|                         | Denial confirmation – For non-urgent (routine) care, the member and provider will be given written or electronic confirmation for the decision within 2 working days of making the decision. |

| Urgent Preauthorization | Decision and notification – Shall occur 72 hours of receipt of request. For denials of urgent care, the member and provider will be notified of the denial and that an expedited appeal can be initiated immediately.  
|                         | Denial confirmation – The member and provider will be given written or electronic confirmation for the decision within 2 working days of making the decision. The letter directs the member on how to file an appeal. |

Continued on next page
The Utilization Management/Case Management Committee reviews and approves the utilization management processes and clinical review criteria used to determine medical necessity. BCBSNM currently uses Milliman Care Guide QI Guidelines clinical protocols and screening criteria to screen preauthorization and concurrent review requests. For more information, contact the UM Department at 1-877-232-5518.

For members who are receiving home and community based services (HCBS), their care coordinator will include all HCBS in the member’s Individualized Care Plan and Individual Service Plan (ISP). Care coordinators may include services up to certain levels without requiring utilization review. BCBSNM determines reasonable service levels for member’s receiving HCBS which the care coordinators use as a guide for determining whether or not the member’s service plan requires utilization review. If the plan is within the guidelines, the care coordinator will submit the care plan to the utilization management department as a notification only, easing the administrative burden for providers who have members services included in the plan. The utilization review department will notify the providers, based on the members care coordination plan, of the authorization for services eliminating the need for the provider to request services individually that are included in the HCBS care plans.

Our licensed behavioral health clinicians base authorization decisions on medical necessity as defined by the State of New Mexico Human Services Department and Medical Assistance Division (MAD-MR: 08-10 8.305.1 NMAC.).
Health Care Management, Continued

Clinical Review Criteria (continued)

For more information about behavioral health services, contact either the BCBSNM Provider Service Unit or the Behavioral Health Team at 1-888-349-3706 directly for assistance.

BCBSNM may develop recommendations or clinical guidelines for the treatment of specific diagnoses, or for the utilization of specific drugs. These guidelines will be communicated to participating providers via the BCBSNM website and Blue Review provider newsletter. Clinical Practice Guidelines are published in the Blues Provider Reference Manual and are located on BCBSNM’s website at www.bcbsnm.com.

Utilization Management Appeals

Member appeals regarding authorization or termination of coverage for a health care service should be mailed or faxed as follows:

- To file a grievance, call 1-866-689-1523, or write to:
  Blue Cross Community Centennial
  ATTN: Grievance Coordinator
  P.O. Box 27838
  Albuquerque, NM 87125-7838
  FAX: 1-888-240-3004

- To file an appeal, call 1-877-232-5520, or write to:
  Blue Cross Community Centennial
  ATTN: Appeals Coordinator
  P.O. Box 27838
  Albuquerque, NM 87125-7838
  FAX: 1-888-240-3004

For an expedited appeal only, call: 1-877-232-5520
Health Care Management, Continued

**Health Risk Assessment**

A Health Risk Assessment (HRA) will be conducted with all new members within 10 days of enrollment. PCPs will be notified of the member’s HRA results via a letter. The purpose of the HRA is to:

- Introduce Blue Cross Community Centennial to the member,
- Obtain basic health and demographic information about the member,
- Assist in determining the member’s risk stratification and indicate the level of care coordination needed by the member, and
- Determine the need for a nursing facility level of care assessment

**Disease Reporting**

As required by the State of New Mexico, Human Services Department (HSD), all participating providers are required to report all applicable diseases as listed in the Notifiable Diseases/Conditions in New Mexico. Any confirmed or suspected diseases require immediate reporting by telephone to the Office of Epidemiology at 505-827-0006.

All reports must include the following:

- The disease or problem being reported
- Patient’s name, date of birth, age, gender, race/ethnicity, address, and telephone number
- Physician’s (or laboratory) name, NPI number, and telephone number
- Other conditions of public health importance

Continued on next page
Health Care Management, Continued

The Condition Management/Disease Management (DM) programs include but are not limited to:

- Asthma for adults and children
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)
- Hypertension
- Obesity
- Depression
- Alcohol and substance abuse disorders
- Anxiety and panic disorders
- Bipolar disorders
- Eating disorders
- Schizophrenia and other psychotic disorders
- Attention Deficit and Hyperactivity Disorder (ADD/ADHD)

Member participation is voluntary, and they receive:

- telephonic health coaching,
- assessment of educational needs,
- gaps-in-care,
- psychosocial needs and assessment of readiness to change, and
- hard copy educational information to enhance self-management of their condition.

To increase compliance with medications and other treatment regimens as ordered by their treating physicians, members are encouraged to track their own symptomology and vital signs. The treating provider is an integral part of the DM program.

In addition, Special Beginnings® prenatal care management is included to reduce the risk of premature babies. Any member who is an expectant mother with maternity coverage may enroll in Special Beginnings at no cost. It includes a health risk assessment; educational materials; a 24-hour nurse line (1-877-213-2567); and OB case management for high-risk pregnancies. For additional information about Special Beginnings, call 1-888-421-7781.
Care Coordination is a BCBSNM service to assist members (and their families) with multiple, complex, cognitive, behavioral, physical, social or special health care needs. The care is person centered, family-focused (when appropriate), and culturally and linguistically competent.

Care Coordination is a process that reviews, plans, and helps members find options and services to meet their health and/or social needs. BCBSNM has a team of physical health and behavioral health Care Coordinators to provide these services. Care Coordination works closely with participating providers to develop a Member Care Plan designed to meet member needs. Providers are expected to participate in this process to assure the members’ needs are being met as part of the Health Care Continuum to include any changes in the member’s status. This process will include, but is not limited to, coordination with other providers, subcontractors or HSD contractors. The Care Coordination team also works closely with the Social Care Services team to ensure that non-Medicaid benefit services are accessed in order to provide the best possible health outcome.

Care Coordination helps ensure the member’s physical health, behavioral health and social needs are fully identified and the necessary services are provided and coordinated by:

- Performing a telephonic HRA upon initial enrollment to BCBSNM and annually thereafter;
- Providing member access to the BCBSNM Care Coordination unit for assistance and for reviewing for potential triggers to a higher risk stratification level when the member is initially stratified into the low risk category during the HRA process;
- Providing a designated Care Coordinator who is primarily responsible for coordinating the member’s health care services for members who are risk stratified as Moderate or High Risk;
- Completion of a Comprehensive Needs Assessment (CNA) for members who are risk stratified as Moderate or High Risk, on an annual or semi-annual basis respectively;
- Development of an Individual Care Plan (ICP) in coordination with the member, their caregiver, and their providers based on the results of the CNA;

Continued on next page
Health Care Management, Continued

Care Coordination (continued)

- Ensuring access to providers who are experts for members with special needs;
- Assisting with coordination of medical and behavioral health services.
- Assisting members who select the Self-Directed Community Benefit in developing their Individual Care Plan and budget, hiring their own caregivers, and ensuring that their provider services remain within their budget on an ongoing basis;
  - Providing chronic disease management education and services;
  - Assisting the member in accessing social resources that are not covered benefits; and
  - Interfacing and collaborating with members’ Complex Case Managers when applicable. The Care Coordinator may also refer the member to Case Management as needed.

For questions regarding the BCBSNM Blue Cross Community Centennial Care Coordination services, contact Case Management Programs at 1-800-325-8334.

Cooperation

Participating providers must comply and cooperate with all Blue Cross Community Centennial Medical Management policies and procedures and the Quality Assurance and Performance Improvement programs, including, but not limited to coordination with other providers, subcontractors or HSD contractors. In addition, participating providers must cooperate with BCBSNM and requests from the External Quality Review Organization (EQRO) retained by HSD/MAD, HealthInsight New Mexico, as well as any medical review agencies authorized by the Human Services Department (HSD) to perform medical review or investigations.

Continued on next page
In order to help providers and their office staff with the care coordination of our members, we offer a Provider One Call unit. This program is staffed by highly trained Health Coordinators who assist providers on a range of issues, including:

- locating contracted specialty services
- locating non-contracted specialty providers where a service gap exists within the state of NM
- coordinating physical health, behavioral health, and social services for Blue Cross Community Centennial members.

For example, if a PCP is concerned about the respiratory status of a member, and has not been able to find a pulmonologist to see the member, by calling our One-Call Unit, they can ask for our assistance to identify, make an appointment with, and arrange transportation for the member to see a pulmonologist. BCBSNM will also ensure that the PCP receives a full report of the specialist’s findings and recommendations after the appointment.

The Health Coordinators also reach out to behavioral health providers on behalf of a physical health provider who needs assistance in finding a service for one of his or her members.

This is a clinical service unit and is not meant to handle claims payment or administrative issues, but rather is fully dedicated to assisting providers to coordinate care for members. If the member is identified as having a social need, the provider can also call the One-Call Unit for assistance and the Community Social Care Services Department for resource assistance. The service greatly reduces the provider’s administrative burden while helping to ensure members receive timely access to all needed care.

Our Provider One Call can be reached at: 1-855-610-9833
Health Care Management, Continued

**Long Term Care**

As part of Blue Cross Community Centennial, BCBSNM provides Home and Community Based Services and personal care services that are available to members meeting the nursing facility level of care.

BCBSNM's goal is to work with providers and community resource partners to identify and facilitate the transition and/or implementation of services for our members who otherwise would qualify for placement in a long-term care (LTC) facility at a nursing facility level of care. The intent is to provide an alternative living arrangement by providing personal care and other appropriate services to help these members maintain as independent a lifestyle as possible safely in the member's preferred place of residence.

BCBSNM is also working with our partners at the State level to meet this goal through a variety of mechanisms. Providers with a member who is either currently institutionalized but has expressed a desire to live in the community, or is a candidate for long term care/nursing facility placement but with some assistance could remain in their preferred place of residence, should contact one of our care coordinators for assistance.

BCBSNM will work with providers, LTC providers and facilities, and State partners to coordinate a safe and sustainable transition that best meets the needs of the member.

**Clinical Guidelines**

Preventive and clinical practice guidelines are based on the health needs and opportunities for improvement identified as part of the Quality Improvement Program. Whenever possible, Blue Cross Community Centennial adopts preventive and clinical practice guidelines that are published by nationally recognized organizations or government institutions as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field.

**Adult Preventive Care**

- [U.S. Preventive Services Task Force Recommendations](#)
- [Adult Immunization Schedule, Center for Disease Control and Prevention (CDC)](#)

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Health Care Management, Continued

<table>
<thead>
<tr>
<th>Clinical Guidelines (continued)</th>
<th>Disease Management (Diabetes, Asthma and Sickle Cell)</th>
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<tr>
<td></td>
<td>• Guidelines for the Diagnosis and Management of Asthma, National Heart, Lung, and Blood Institute</td>
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<td>• Guidelines for the Diagnosis and Management of Asthma</td>
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<td>• Standards of Medical Care in Diabetes</td>
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<td>• Executive Summary: Standards of Medical Care in Diabetes—2010</td>
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<td></td>
<td>• Management of Sickle Cell</td>
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<td></td>
<td>• Diagnosis and Management of Stable Chronic Obstructive Pulmonary Disease (COPD)</td>
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<td></td>
<td>• Clinical Practice Guidelines for Chronic Obstructive Pulmonary Disease (COPD)</td>
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</table>

Cardiac Conditions
• Diagnosis and Evaluation of Chronic Heart Failure
• ACCF/AHA Guidelines for the Diagnosis and Management of Heart Failure in Adults

Behavioral Health
• Cenpatico Behavioral Health Clinical Practice Guidelines
• Department of Veterans Affairs/Department of Defense clinical practice guideline for management of major depressive disorder (MDD)
• Using Second-Generation Antidepressants to Treat Depressive Disorders
• Practice Guidelines for Psychiatric Consultation in the General Medical Setting

Pharmacy
• American Society of Health-System Pharmacists’ Guidelines on the Pharmacy and Therapeutics Committee and the Formulary System

Continued on next page
Health Care Management, Continued

**Clinical Guidelines (continued)**

**Community Reintegration & Support**
- The Guide to Community Preventive Services
- Clinical Guidelines for Seniors Falls Prevention
- Management of Adult Stroke Rehabilitation Care
- Clinical Practice Guidelines for Quality Palliative Care

**Long Term Care Residential Care Coordination**
- Transitions of Care in the Long-term Care Continuum

**Dental**
- Oral hygiene Care for Functionally Dependent and Cognitively Impaired Older Adults
Provider Performance Standards and Compliance Obligations

Participating providers must comply with all applicable laws and licensing requirements. Covered services must be furnished in a manner consistent with standards related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment. Standards must be complied with, which include but are not limited to:

- Guidelines established by the Centers for Disease Control and Prevention (or any successor entity)
- All federal, state, and local laws regarding the conduct of their profession

Policies and procedures must also be complied with regarding:

- Participation on committees and clinical task forces to improve the quality and cost of care
- Preauthorization requirements and time frames
- Credentialing requirements
- Care Management and Condition Management/Disease Management Program referrals
- Appropriate release of inpatient and outpatient utilization and outcomes information
- Accessibility of member medical record information to fulfill the business and clinical needs of Blue Cross Community Centennial
- Providing treatment to patients at the appropriate level of care
- Maintaining a collegial and professional relationship with Blue Cross Community Centennial personnel and fellow participating providers
- Providing equal access and treatment to all members

Participating providers acting within the lawful scope of practice are advised to inform members about:

- The patient’s health status, medical care, or treatment options (including any alternative treatments that may be self-administered, and any abnormal medical or lab test results), including the provision of sufficient information to provide an opportunity for the patient to make an informed decision from all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions

Such actions shall not be considered non-supportive of Blue Cross Community Centennial and Blue Cross Community Centennial will never adopt any policy or practice that prohibits providers from advising members about their health status, medical care, or treatment options.

Continued on next page
**Primary Care Physician (PCP) Responsibility**

PCP responsibilities include the following:

- Assure access to care 24 hours a day, 7 days a week
- Coordination and continuity of care with providers who participate within the MCO network and with providers outside the MCO network according to MCO policy, including all behavioral health and long-term care providers
- Maintenance of current medical records for the member, including documentation of services provided to the member by the PCP and specialty or referred service
- Ensuring the provision of services under the EPSDT program is based on the periodicity schedule for members under age 21
- Vaccinating members in their office and not referring members elsewhere for immunizations
- Ensuring the member receives appropriate preventive services for their age group
- Ensuring that care is coordinated with other types of health and social program providers
- Governing how coordination with the PCP will occur with hospitals that require in-house staff to examine or treat members having outpatient or ambulatory surgical procedures performed
- Governing how coordination with the PCP and hospitalists will occur when an individual with a special health care need is hospitalized
- Identify and report Critical Incidents as defined in the Provider Performance Standards and Compliance Obligations section of this manual
- Participating in the member’s care planning process when requested by the BCBSNM care coordinator

*Continued on next page*
Primary Care Physician (PCP)
Responsibility (continued)

- Ensuring that a member is referred to a behavioral health provider based on the following indicators:
  - Suicidal/homicidal ideation or behavior
  - At-risk of hospitalization due to a behavioral health condition
  - Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital or residential treatment facility
  - Trauma victims
  - Serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment, mental retardation, or other developmental disabilities
  - Request by member or representative for behavioral health services
  - Clinical status that suggests the need for behavioral health services
  - Identified psychosocial stressors and precipitants
  - Treatment compliance complicated by behavioral characteristics
  - Behavioral and psychiatric factors influencing medical condition
  - Victims or perpetrators of abuse and/or neglect and members suspected of being subject to abuse and/or neglect
  - Members suspected of being subject to Abuse and/or neglect; Non-medical management of substance abuse
  - Follow-up to medical detoxification
  - An initial PCP contact or routine physical examination indicates a substance abuse problem;
  - A prenatal visit indicates substance abuse problems;
  - Positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse;
  - A pattern of inappropriate use of medical, surgical, trauma or emergency room services that could be related to substance abuse or other behavioral health conditions; and/or the persistence of serious functional impairment.
  - Ensuring that care is coordinated with a member’s behavioral health provider when the member has given written permission to do so.

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Beginning July 1, 2014, BCBSNM began using an Electronic Visit Verification (EVV) system as mandated by the State of New Mexico Human Services Department Centennial Care program. Provided by First Data, the EVV system, AuthentiCare®, tracks visits related to community benefits.

**The system**

- Is web-based and paperless
- Allows the provider to review the claim before confirming it for submittal
- Generates claims automatically
- Gives providers the ability to create reports and report templates
- Provides real-time service information to providers and care coordinators
- Requires access to the internet (a high-speed broadband internet connection is recommended)

Using the member’s landline or employee’s smart phone, claims are generated automatically when an agency employee calls a toll-free phone number from the consumer’s home at the beginning and end of service. The employee’s unique ID number and the consumer’s phone number or GPS location are used to verify the service being provided and the consumer receiving the service. AuthentiCare submits the claim for adjudication after the provider reviews and confirms it via the web.

There is no cost to the provider to use AuthentiCare. Providers will be trained to use the system and will receive training materials for use when training others in their agencies.

All claims for the services below must be submitted through the AuthentiCare New Mexico Centennial Care system:

- Personal Care – Consumer Delegated
- Personal Care – Consumer Directed
- Personal Care – Consumer Directed Administrative Fee
- Personal Care – Consumer Directed Training
- Personal Care – Consumer Directed Advertisement Reimbursement
- Homemaker Respite

*Continued on next page*
Provider Performance Standards and Compliance Obligations, Continued

Home Health Agency Documentation

Home Health Agencies are required to document face-to-face encounters as indicated in the Medical Assistance Program Manual Supplement 11-07. Also visit the Centers for Medicare and Medicaid Services’ Home Health Agency Center website.

Laws Regarding Federal Funds

Payments that participating providers receive for furnishing services to members are, in whole or part, from federal funds. Therefore, participating providers and any of their subcontractors must comply with certain laws that are applicable to individuals and entities receiving federal funds, including but not limited to:

- Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84,
- Age Discrimination in Employment Act of 1975 as implemented by 45 CFR part 91,
- Rehabilitation Act of 1973, and
- the Americans With Disabilities Act.

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Provider Disclosure Regarding Certain Criminal Convictions, Ownership and Control Information

Before entering into or renewing a Blue Cross Community Centennial provider contract, within 35 days after a change in ownership in a Blue Cross Community Centennial provider, or at any time on request, providers are required to complete, sign, and return the Provider Disclosure form regarding certain criminal convictions, ownership and control information. The Provider Disclosure form can be found in the Attachment Section at the end of this manual and on our website and should be submitted with the application packet to contract for Blue Cross Community Centennial in addition to other times described herein.

Additionally, within 35 days of request by BCBSNM, Blue Cross Community Centennial providers are required to submit full and complete information about:

- the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request, and
- any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

Providers are required to collect and maintain disclosure information regarding certain criminal convictions, ownership and control information as described in this Section.

Continued on next page
Provider Performance Standards and Compliance Obligations,
Continued

Sanctions under Federal Health Programs and State Law

Participating providers certify that to the best of their knowledge neither they nor their employees or subcontractors have been:

(a) Charged with a criminal offense in connection with obtaining, attempting to obtain, or performing of a public (federal, state, or local) contract or subcontract;
(b) Listed by a federal governmental agency as debarred;
(c) Proposed for debarment or suspension or otherwise excluded from federal program participation;
(d) Convicted of or had a civil judgment rendered against them regarding dishonesty or breach of trust (including but not limited to the commission of a fraud including mail fraud or false representations, violation of a fiduciary relationship, violation of federal or state antitrust statutes, securities offenses, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property); or
(e) Within a three-year period preceding the date of this Agreement, had one or more public transactions (federal, state, or local) terminated for cause or default;
(f) Not excluded from participation from Medicare, Medicaid, federal health care programs, or federal behavioral health care programs pursuant to Title XI of the Social Security Act, 42 U.S.C. § 1320a-7 and other applicable federal statutes.

Participating providers certify that public sources of information are checked to confirm that its vendors have not been:

(a) Listed by a federal governmental agency as debarred; or
(b) Proposed for debarment or suspension or otherwise excluded from federal program participation.

Participating providers must disclose to BCBSNM whether the provider, staff member, or subcontractor has any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws; the rules or regulations of the state of New Mexico; the federal government; or any public insurer. BCBSNM must be notified immediately if any such sanction is imposed on a participating provider, staff member, or subcontractor.

Note: Federal Exclusion website:
http://oig.hhs.gov/exclusions/index.asp

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Provider Performance Standards and Compliance Obligations, Continued

Provider Preventable Conditions

BCBSNM complies with regulations issued by the Centers for Medicare and Medicaid Services, under Section 2702 of the Affordable Care Act, which calls for non-payment for provider preventable conditions (PPCs) including health care acquired conditions (HCACs) and Never Events. BCBSNM will not pay claims for members receiving care related to HCACs and Never Events in any health care setting.

See Section 6.5 Facility and Ancillary Providers in the Commercial portion of this manual as well as Supplement 12-05 on the New Mexico Human Services website for a description of HCACs and Never Events.

Cultural Competency and Diversity

Participating providers are required to complete computer-based training on Cultural Competency that can be located in the Provider Section of our website at bcbsnm.com under Network Participation/Medicaid. Select the Resources tab to display this training option. Once providers complete the training, an attestation of completion will be provided and a copy will be added to the provider’s contract file.

Providers must understand cultural competency as it pertains to their practice. Cultural competency refers to a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals, and enables them to work effectively in cross-cultural situations. Cultural competency involves the integration and transformation of knowledge, information, and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques, and marketing programs that match an individual’s culture and increase the quality and appropriateness of health care and outcomes. Providers must take into consideration the member’s racial and ethnic group, including their language, histories, traditions, beliefs, and values when rendering or referring members for medical services.

Participating providers are also encouraged to respect and value human diversity and make a good faith, reasonable effort to utilize minority, women, and disabled owner business enterprises in the performance of services provided under the Blue Cross Community Centennial plan.

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Cultural Competency and Diversity (continued)

Participating providers are expected to provide an interpreter when the member does not speak or understand the language that is being spoken.

BCBSNM provides members with access to a bilingual customer service staff, a Language Interpreter Line, and Relay New Mexico - a teletypewriter TTY service. All of these numbers are found on the back of each member's ID card as well as in the Contact List.

Critical Incident Management

All allegations of abuse, neglect (including self-neglect), and exploitation, or incidents involving emergency services, natural or unexpected deaths, environmental hazards, and any incidents involving law enforcement, must be reported to HSD by use of the Critical Incident Reporting system.

Incident Reports are submitted to HSD for each recipient through the HSD Critical Incident Management website: https://criticalincident.hsd.state.nm.us

Reporting abuse, neglect or exploitation to HSD does not relieve a provider of mandated reporting requirements to Adult Protective Services (APS).

Providers that do not comply with incident reporting requirements are in violation of State statute and Medicaid regulations and may be sanctioned up to, and including, termination of their provider agreements by BCBSNM or by the HSD Medical Assistance Division.

Reporting Suspected Abuse, Neglect and Exploitation of Members

If providers suspect abuse, neglect or exploitation of members, they are mandated by law to contact Adult Protective Services at:

Adult Protective Services Statewide Central Intake
Telephone: 866-654-3219
Fax: 505-476-4913

Continued on next page
Provider Performance Standards and Compliance Obligations, Continued

Reporting Abuse and Critical Incidents

In addition, providers are required to report all allegations of suspected abuse, neglect or exploitation and critical incidents to BCBSNM by calling any of the following numbers:

- (Preferred) Case Management (CM) Programs: 1-800-325-8334
- Provider One Call: 1-855-610-9833
- Provider Customer Service: 1-888-349-3706

BCBSNM will contact, as appropriate, any or all of the following agencies for assistance or intervention:

- Adult Protection Services
- Child Protection Services: CYFD Statewide Central Intake, law enforcement, or appropriate tribal entity
- New Mexico HSD, Medical Assistance Division Quality Bureau
- New Mexico Ageing and Long-Term Services Department/Elderly and Disability Services Division

If there appears to be an issue of an urgent or emergent nature which endangers a member, the health care professional should report the incident to the Child Protective Services or Adult Protective Services after calling 911 to report.

It is the responsibility of health care professionals to report witnessed or reported incidents of child, adult, or elder abuse or neglect to CYFD/Child Protective Services or to Adult Protective Services for investigation. The entire staff of BCBSNM has the right and responsibility to report any of these occurrences.

Continued on next page
If abuse issues are noted by a BCBSNM Care Coordination team member at an on-site visit or discussed telephonically, these issues are reported to a health care professional in the team at that facility.

If the incident is received from a non-BCBSNM employed health professional (a provider of services such as PCP or physical therapist), they will be encouraged to make the report since they are the direct provider of health care, closer to the situation and member and the most appropriate professional to notify the agency. Health Services staff will follow up on the situation.

BCBSNM applies the following principles to our Critical Incident Management Program:

- Participants should have a quality of life that is free of abuse, neglect, and exploitation
- Any individual who, in good faith, reports an incident or makes an allegation of abuse, neglect, or exploitation will be free from any form of retaliation
- A provider’s incident management system must emphasize prevention and staff involvement in order to provide safe environments for the individuals they serve
- Quality starts with those who work most closely with persons receiving services

Reportable Critical Incidents include:

- For adults, 18 and older: abuse, neglect, and exploitation; death; other reportable incidents such as environmental hazards, law enforcement intervention, and emergency services
- For children, under 18 years: Physical abuse; sexual abuse; neglect; death; other reportable incidents such as environmental hazards, law enforcement intervention, and emergency services
Department of Child Welfare has identified the signs of child abuse, neglect, sexual abuse, and mental maltreatment as follows:

- **Signs of Physical Abuse** – consider the possibility of physical abuse when the child
  - Has unexplained burns, bites, bruises, broken bones, or black eyes
  - Has fading bruises or other marks noticeable after an absence from school
  - Seems frightened of the parents and protests or cries when it is time to go home
  - Shrinks at the approach of adults
  - Reports injury by a parent or another adult caregiver

- **Signs of Physical Abuse** - consider the possibility of physical abuse when the parent or other adult caregiver
  - Offers conflicting, unconvincing, or no explanation for the child's injury
  - Describes the child as "evil," or in some other very negative way
  - Uses harsh physical discipline with the child
  - Has a history of abuse as a child

- **Signs of Neglect** - consider the possibility of neglect when the child
  - Is frequently absent from school
  - Begs or steals food or money
  - Lacks needed medical or dental care, immunizations, or glasses
  - Is consistently dirty and has severe body odor
  - Lacks sufficient clothing for the weather
  - Abuses alcohol or other drugs
  - States that there is no one at home to provide care

- **Signs of Neglect** - consider the possibility of neglect when the parent or other adult caregiver
  - Appears to be indifferent to the child
  - Seems apathetic or depressed
  - Behaves irrationally or in a bizarre manner
  - Is abusing alcohol or other drugs

*Continued on next page*
Critical Incident Management and Reporting Suspected Abuse, Neglect and Exploitation of Members (continued)

- **Signs of Sexual Abuse** - consider the possibility of sexual abuse when the child
  - Has difficulty walking or sitting
  - Suddenly refuses to change for gym or to participate in physical activities
  - Reports nightmares or bedwetting
  - Experiences a sudden change in appetite
  - Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
  - Becomes pregnant or contracts a venereal disease, particularly if under age 14
  - Runs away
  - Reports sexual abuse by a parent or another adult caregiver

- **Signs of Sexual Abuse** - consider the possibility of sexual abuse when the parent or other adult caregiver
  - Is unduly protective of the child or severely limits the child's contact with other children, especially of the opposite sex
  - Is secretive and isolated
  - Is jealous or controlling with family members

- **Signs of Emotional Maltreatment** - consider the possibility of emotional maltreatment when the child
  - Shows extremes in behavior, such as overly compliant or demanding behavior, extreme passivity, or aggression
  - Is either inappropriately adult (parenting other children, for example) or inappropriately infantile (frequently rocking or head-banging, for example)
  - Is delayed in physical or emotional development
  - Has attempted suicide
  - Reports a lack of attachment to the parent

- **Signs of Emotional Maltreatment** - consider the possibility of emotional maltreatment when the parent or other adult caregiver:
  - Constantly blames, belittles, or berates the child
  - Is unconcerned about the child and refuses to consider offers of help for the child's problems
  - Overtly rejects the child

*Continued on next page*
Critical Incident Management and Reporting Suspected Abuse, Neglect and Exploitation of Members

The Institute on Aging has identified the possible signs of elder abuse as the following:

General Indicators
- Reluctance to provide access or answer questions;
- Implausible or vague explanations for situations;
- Irregular pattern of behavior.

Home
- Newspapers/mail accumulating;
- Lack of attention to house;
- Large numbers of people using home;
- Drug activity;
- Odd noises, bad odors.

Financial
- Irregular pattern of spending/withdrawals;
- Frequent purchases of inappropriate items; withdrawals made in spite of penalties; bills not paid; utilities turned off; talks about meeting a "new best friend."

Physical Signs
- Multiple bruises;
- Pattern injuries;
- Elder lacks necessary helping devices.

Mental Health/Emotional Signs
- Elder is depressed, appears to have dementia, shows signs of anxiety, fears a caregiver, and/or is isolated by the caregiver.

Caregiver
- Caregiver is excessively concerned about costs of services or supplies, attempts to dominate elder, is verbally abusive of elder or you, and/or shows evidence of substance abuse or mental health problems. Financial dependence on the elder is also a warning sign.
Employee Abuse Registry Act

All participating providers covered by the Employee Abuse Registry Act, NMSA 1978 Sections 27-7A-1 to 27-7A-8, are required to inquire the Department of Health’s Employee Abuse Registry (“Registry”) as to whether an employee is included in the Registry before hiring or contracting with the employee.

Participating providers covered by the law include, but are not limited to:
- Intermediate care facilities for the mentally retarded
- Rehabilitation facilities
- Home health agencies
- Group homes
- Adult foster care homes
- Homes for the aged or disabled
- A case management entity that provides services to elderly people or people with developmental disabilities

Participating providers must document that they have checked the Registry for each applicant before the applicant was considered for employment or contract.

Participating providers cannot hire or contract with an employee in a direct care setting who is included in the Registry.

Marketing or Outreach Activities

Participating providers cannot engage in any marketing or outreach activities without prior approval from BCBSNM. All marketing or outreach activities must comply with state and federal guidelines.

List of Excluded Individuals/Entities (LEIE)

Providers are required to screen all employees against the List of Excluded Individuals/Entities (LEIE) monthly to ensure they are not employing or contracting with excluded individuals.
Selection and Retention of Participating Providers

To participate in Blue Cross Community Centennial, all providers:

- Must be a participating provider with BCBSNM.
- Must have privileges at one of the Blue Cross Community Centennial participating hospitals (unless inpatient admissions are uncommon or not required for the provider’s specialty).
- Must have a valid National Provider Identifier (NPI).
- Must sign a Medicaid Amendment to his or her Medical Services Entity Agreement with BCBSNM.
- Cannot have any sanctions or reprimands by any licensing authority or review organizations. Participating providers cannot be named on the Office of the Inspector General (OIG) or Government Services Administration (GSA) lists which identify providers found guilty of fraudulent billing and/or misrepresentation of credentials.
- Background checks including verification of sanctions prohibiting participation within government programs will be run prior to employment. Review of the List of Excluded Individual Entities (LEIE) and the System of Award Management (SAM) will be utilized in this review.
- Cannot be sanctioned by the Office of the Personnel Management or prohibited from participation in the Federal Employees Health Benefit Program (FEHBP).

Websites:
www.sam.gov/portal/public/SAM
http://oig.hhs.gov/exclusions/index.asp

Continued on next page
Selection and Retention of Participating Providers, Continued

The Human Services Department (HSD) requires any provider who files a New Mexico Medicaid claim with a Managed Care Organization (MCO) for Centennial Care, and is not currently enrolled as either a Fee for Service (FFS) or Managed Care only provider to register on the NM Medicaid Provider Web Portal.

MCO-only registration is located within the provider enrollment section that includes the Managed Care Organization (MCO) network only option and the Non-network Managed Care Organization (MCO) option. Select one of these options and complete the enrollment process. The following providers must be registered:

- Solo providers type 1 NPI
- Groups type 2 NPI (includes ancillary, facility, professional, etc.)
- Individuals within a group
- Providers with multiple NPI numbers that render services to NM Medicaid members must register each applicable NPI number
- Atypical providers that are not required to have an NPI but, are required to register (personal care services, environmental modification, etc.)

If you have multiple NPI numbers that are utilized to render services to NM Medicaid members, each NPI must be registered. Regardless of participation status with an MCO, the State requires you to be enrolled in order to receive Medicaid reimbursement.

If you are already registered, re-registration will not be required. Please ensure that each practitioner in your practice is registered. All enrollment information (changes to demographics, licensure or certification, provider status, etc.) must be updated on the NM Medicaid Provider Web Portal.

Refer to the HSD Frequently Asked Questions (FAQs) document for more information.
Selection and Retention of Participating Providers, Continued

Credentialing is the process by which BCBSNM ensures that the physicians and certain other providers meet the professional standards that are described in the Credentialing Policy. The credentialing standards cover areas such as education, advanced training, board certification, licensure, disciplinary action, and legal action.

BCBSNM continuously reviews and evaluates information and re-credentials participating providers every three years. The credentialing guidelines are subject to change based on industry requirements and Blue Cross Community Centennial standards.

BCBSNM continuously reviews and evaluates Institutional provider information and recertifies Institution providers every three years. The certification guidelines are subject to change based on industry requirements and Blue Cross Community Centennial standards.

Credentialing is not synonymous with participation on a BCBSNM network. Only physicians or other providers who are determined by the Credentialing Committee as having met credentialing standards are eligible for participation with BCBSNM. Due to state regulations and National Committee for Quality Assurance (NCQA) standards, we are required to perform primary source verification, where applicable, on a number of elements used for establishing credentials.

Provider Rights:
- In the event that the credentialing information obtained from other sources varies substantially from that attested to by the provider, and the discrepancy affects or is likely to adversely affect the credentialing or recredentialing decision, we will notify the provider of the discrepancy.
- The provider will have the right to review information provided in support of his/her application and to correct erroneous information. Providers have the right to review information obtained by BCBSNM at any time except for information or recommendations that are protected by peer review.
- The provider has the right to receive the status of his/her credentialing or recredentialing application, upon request.

Refer to Section 16 – Credentialing of the Blues Provider Reference Manual for a complete description of the BCBSNM credentialing process.

Continued on next page
Selection and Retention of Participating Providers, Continued

Home and Community-Based Services (HCBS)

Atypical providers are those who care for members requiring long-term care services also known as Home and Community-Based Services (HCBS). HCBS providers include but are not limited to:

- Adult Day Health
- Assisted Living Facilities
- Emergency Response Service
- Environmental Modifications
- Personal Care Services
- Private Duty Nursing for Adults
- Respite Services
- Support Brokers

If you are interested in contracting with BCBSNM please contact us at 505-837-8800 or 1-800-567-8540.

Appeals to Network Terminations

A provider who does not continue to meet credentialing standards will no longer be eligible for participation in the network. In those cases, BCBSNM will terminate its provider agreements with the provider. When a provider’s relationship is terminated for cause, a 30-day notice is provided and BCBSNM offers a full set of appeal rights, including the right to correct erroneous information and the right to an informal fair hearing in compliance with all applicable Division of Insurance regulations regarding provider terminations contained within the New Mexico Managed Health Care Plan Rule. These appeal rights are described in detail in Section 15, Resolution of Provider Disputes.

Notification to Members of Provider Termination

BCBSNM will make a good faith effort to provide written notice of a termination of a participating provider to all members who are patients seen on a regular basis by that provider at least 15 calendar days before the termination effective date, regardless of the reason for the termination.

Continued on next page
Selection and Retention of Participating Providers, Continued

**Standards for Medical Records**

Participating providers must have a system in place for maintaining medical records for a period of not less than ten years that conforms to regulatory standards. Each medical encounter whether direct or indirect must be comprehensively documented in the member’s medical chart.

Refer to the Medical Records Documentation Standards in Section 16 of the *Blues Provider Reference Manual*, or in the Standards & Requirements section of our provider website. For additional information on HIPAA compliance standards and medical records, see Section 7.3, pages 7-4 to 7-11 of the *Blues Provider Reference Manual*.

**Change in Provider Information**

Changes in practitioner demographic information should be reported immediately upon availability to BCBSNM Network Services and to the New Mexico Medicaid provider web portal.
Selection and Retention of Participating Providers, Continued

Appeal Process for Provider Participation Decisions

If BCBSNM decides to suspend, terminate, or non-renew a provider’s participation status, BCBSNM will give the affected provider written notice of the reason for the action including, if relevant, the standards and profiling data used to evaluate the provider and the numbers and mix of providers needed for the Blue Cross Community Centennial network.

BCBSNM will allow the provider to appeal the action to a hearing panel, and give the provider written notice of his or her right to an appeal hearing and the process and timing for requesting a hearing. BCBSNM will ensure that the majority of the hearing panel members are peers of the affected provider. A recommendation by the hearing panel is advisory and is not binding on BCBSNM.

When BCBSNM terminates a provider from the network, it notifies the provider in writing at least 90 calendar days in advance of the effective date of the termination, unless BCBSNM determines there is imminent risk to the health and safety of its members. This is in accordance with the expedited termination process described in Section 15.4.6 of the Blues Provider Reference Manual.

If a reduction, suspension or termination of a participating provider’s participation is final and is the result of quality of care deficiencies, BCBSNM will notify the National Practitioner Data Bank and any other applicable licensing or disciplinary body to the extent required by law.

Subcontracted physician/professional provider groups must certify that these procedures apply equally to providers within those subcontracted groups. (Note: refer to Section 15.4.3., Provider Appeal Rights and Responsibilities, for further instructions on the appeal process for provider terminations.)
Medical Records

Medical Record Review
A BCBSNM representative may request medical records and/or visit the provider's office to review the medical records of Blue Cross Community Centennial members as described in the *Blues Provider Reference Manual*.

Standards for Medical Records
Participating providers must have a system in place for maintaining medical records for a period of not less than ten years that conforms to regulatory standards. Each medical encounter whether direct or indirect must be comprehensively documented in the member’s medical chart.

Refer to the Medical Records Documentation Standards in Section 16 of the *Blues Provider Reference Manual*, or in the Standards & Requirements section of our provider website. For additional information on HIPAA compliance standards and medical records, see Section 7.3, HIPAA Compliance.

Transfer of Medical Records
The physician or physician group practice is responsible for making appropriate arrangements for the disposition of medical records when a practice closes.

The recommended period for record retention is:

- Adult patients—10 years from the date the patient was last seen.
- Minor patients—28 years from the patient’s birth.
- Mammography patients—10 years from last mammography.
- Deceased patients—five years from the date of death.

Refer to Section 4.4, Professional Provider Responsibilities of the *Blues Provider Reference Manual* for more information about transferring medical records.
Initial Decisions, Appeals, and Grievances

Initial Decisions

The “initial decision” is the first decision BCBSNM makes regarding coverage or payment for care. In some instances, a participating provider, acting on behalf of a member, may make a request for an initial inquiry regarding whether a service will be covered.

- If a member asks BCBSNM to pay for medical care already received, this is a request for an “initial decision” about payment for care.
- If a member, or participating provider acting on behalf of a member, asks for preauthorization for treatment, this is a routine request for a preauthorization about whether the treatment is covered by Blue Cross Community Centennial.
- If a member asks for a specific type of medical treatment from a participating provider, this is a request for an “initial decision” about whether the treatment the member wants is covered by Blue Cross Community Centennial.

BCBSNM will generally make decisions regarding payment for care that members have already received within 30 calendar days.

A decision about whether Blue Cross Community Centennial will cover medical care can be a “standard decision” that is made within the standard time frame (typically within 14 calendar days) or an expedited decision that is made more quickly (typically within 72 hours).

A member can ask for an expedited decision only if the member or any provider believes that waiting for a standard decision could jeopardize the life or health of the member or the member’s ability to regain maximum function. The member or a provider can request an expedited decision. If an expedited decision is requested by the member or provider, BCBSNM will automatically provide an expedited decision.

If BCBSNM does not make a decision within the time frame and does not notify the member regarding why the time frame must be extended, the member can treat the failure to respond as a denial and may appeal as set forth below.

Continued on next page
Members/providers have the right to submit a grievance if they have concerns or problems related to their coverage or care. All participating providers must cooperate in the Blue Cross Community Centennial appeals and grievances process.

- An “appeal” is a request for review by BCBSNM for services for a member that are reduced, denied, or limited. This includes requests for pharmacy, transportation, or where BCBSNM did not complete an authorization on time.
- A “grievance” is any expression of dissatisfaction about any matter or aspect of BCBSNM, or its Blue Cross Community Centennial operation made by a member or a participating provider. For example, a complaint concerning quality of care, waiting times for appointments or in the waiting room, and the cleanliness of the participating providers’ facilities are grievances.

BCBSNM tracks all appeals and grievances to identify areas of improvement for Blue Cross Community Centennial. This information is reviewed by the Quality Improvement Committee.

If a provider has a dispute about claims reimbursement, contractual or operational disputes, etc., refer to Section 15 – Resolution of Provider Disputes in the Blues Provider Reference Manual.

Appeals regarding authorization for, or termination of coverage of, a health care service should be mailed, phoned or faxed as follows:

- For member appeals or grievances:
  Medical and Behavioral Health Care:
  ATTN: Blue Cross Community Centennial Appeals
  P.O. Box 27838
  Albuquerque, NM 87125-7838
  Call: 1-877-232-5520
  Fax #: 1-888-240-3004

  For an expedited appeal, call: 1-877-232-5520

- For provider appeals or grievances, contact:
  BCBSNM Provider Service Unit (PSU)
  1-888-349-3706
Initial Decisions, Appeals, and Grievances, Continued

Resolving Grievances and Complaints

If a member has a grievance about Blue Cross Community Centennial, a provider or any other issue, participating providers should instruct the member to contact the Customer Service Department at the number listed on the back of the member’s ID card.

If a provider has a grievance about Blue Cross Community Centennial, another provider or any other issue, participating providers should contact the Provider Service Unit at 1-888-349-3706.

Resolving Appeals

A member/provider may appeal a notice of action concerning authorization for, or termination of coverage of, a health care service. An appeal of a notice of action must be filed within 90 calendar days and will be resolved in 30 calendar days or sooner if the member’s health condition requires. A member appeal may be extended by 14 calendar days if the member requests an extension or BCBSNM determines it is in the member’s best interest to request an extension. In this case BCBSNM will request the extension from HSD. Once BCBSNM receives approval, a written notice will be sent with the extension and the reason for extension within two business days of the decision to extend the timeframe.

If the normal time-period for an appeal could jeopardize the life or health of the member or the member’s ability to regain maximum function, the member or the member’s provider can request an expedited appeal. Such appeal is generally resolved within 72 hours unless it is in the member’s interest to extend this time-period.

Participating Provider Obligations – Organization Determinations

At each patient encounter with a member, the participating provider must notify the member of his or her right to receive, upon request, a detailed written notice from BCBSNM regarding the member’s services. The provider’s notification must provide the member with the information necessary to contact BCBSNM and must comply with any other requirements specified by HSD. If a member requests BCBSNM to provide a detailed notice of a provider’s decision to deny a service in whole or part, BCBSNM must give the member a written notice of the determination.

Continued on next page
Initial Decisions, Appeals, and Grievances, Continued

**Participating Provider Obligations – Appeals**

Participating providers must also cooperate with BCBSNM and members in providing necessary information to resolve the appeals within the required time frames. Providers must provide the pertinent medical records and any other relevant information. In some instances, providers must provide the records and information in an expedited manner to allow BCBSNM to make an expedited decision.

Use the [Provider Request for Appeal on Behalf of a Medicaid Member](#) form when submitting these requests.
Member Rights and Responsibilities

Members have been informed that they have the following rights, including, but not limited to:

- Health care when medically necessary as determined by a medical professional or BCBSNM; 24 hours per day, 7 days per week for urgent or emergency care services, and for other health care services as defined in the member handbook.
- Receive health care that is free from discrimination.
- Be treated with respect and recognition of your dignity and right to privacy.
- Choose a primary care physician (PCP) or provider from the BCBSNM network and be able to refuse care from certain providers (a preauthorization may be necessary to see some providers).
- Receive a copy of, as well as make recommendations about BCBSNM's member rights and responsibilities policy.
- Be provided with information about BCBSNM’s member rights and responsibilities, policies and procedures regarding products, services, providers, appeals procedures, and other information about the company and get information about how to access covered services and the providers in our network.
- Receive a paper copy of the official Privacy Notice from BCBSNM upon request (even if you have already agreed to receive electronic Privacy Notices).
- Receive information in compliance with the Americans with Disabilities Act (ADA).
- Be given the name and professional background of anyone involved in your treatment and the name of the person primarily responsible for your care.
- Choose a surrogate decision-maker to be involved and assist with care decisions as appropriate. This can be done by you or your legal guardian.
- Have an interpreter present when you do not speak or understand the language that is being spoken.

Continued on next page
Member Rights and Responsibilities, Continued

- Participate with your provider in all decisions about your health care, including gaining an understanding of your physical and/or behavioral condition, being involved in your treatment plan, deciding on acceptable treatments, and knowing your right to refuse health care treatment or medication after possible consequences have been explained in a language you understand. Family members, legal guardians, representatives or decision-makers also have this right, as appropriate.

- Talk with your provider about treatment options, risks, alternatives, and possible results for your health conditions, regardless of cost or benefit coverage and have this information documented in your medical record. If you cannot understand the information, the explanation will be provided to your family, guardian, representative or surrogate decision-maker.

- Give informed consent for physical and/or behavioral health medical services.

- Decide on advance directives for your physical and/or behavioral health care. These decisions can be made by you or your legal guardian as allowed by law.

- Access your medical records in accordance with the applicable federal and state laws, which means that you have the right to receive communications about your private records, request a change or addition if you feel they are incomplete or wrong, and request restricted disclosure of your medical records, and the right to be notified if accidental disclosure occurs. If the member has a legal guardian, the legal guardian has the right to access the member's medical records.

- Request a second opinion from another BCBSNM provider. This can be done by you or your legal guardian.

- File a complaint, appeal, or fair hearing about BCBSNM or the care that you received and receive an answer within a reasonable time. Complaints can be filed with BCBSNM and/or New Mexico Human Services Department without fear of retaliation.

- Receive prompt notification of termination or changes in benefits, services, or provider network.

- Be free from harassment from BCBSNM or its network providers in regard to contractual disputes between BCBSNM and providers.

Continued on next page
Member Rights and Responsibilities, Continued

Member Rights (continued)

- Select a health plan and exercise switch enrollment rights without threats or harassment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal or New Mexico regulations on the use of restraints and seclusion.
- Exercise rights without concern that care will be negatively affected.
- Receive information on available treatment options and alternatives in an understandable manner.

Member Responsibilities

Members and member representatives have the following responsibilities:

- Give complete health information to help the provider give the care needed.
- Follow the treatment plan and instructions for medications, diet and exercise as agreed upon by the member and provider.
- Do their best to understand their physical and/or behavioral health conditions and take part in developing treatment goals agreed upon by the member and provider.
- Make appointments ahead of time for provider visits.
- Keep their appointment, or call the provider to reschedule or cancel at least 24 hours before the appointment.
- Tell providers if they do not understand explanations about their health care.
- Treat the provider and other health care employees with respect and courtesy.
- Show their ID card to each provider before getting medical services (or they may be billed for the service).
- Know the name of their PCP and have their PCP provide or arrange their care.
- Call their PCP or the 24/7 Nurseline before going to an emergency room, except in situations that they believe are life threatening, or that could permanently damage their health, or if they are having thoughts of harm to themselves or others.

Continued on next page
Member Rights and Responsibilities, Continued

Member Responsibilities (continued)

- Tell the New Mexico Human Services Department and BCBSNM about changes to their phone number or address.
- Tell BCBSNM if they have other health insurance, including Medicare.
- Give a copy of their living will and advance directives regarding their physical and/or behavioral health to their PCP to include in their medical records.
- Read and follow the member handbook.

Member Satisfaction

BCBSNM periodically surveys members to measure overall customer satisfaction as well as satisfaction with the care received from participating providers. BCBSNM will also work collaboratively with HSD and the Behavioral Health Collaborative to identify items to include in surveys from the Mental Health Statistics Improvement Program (MHSIP) survey and any additional population-specific items. Survey information is reviewed by BCBSNM and results are shared with the participating providers.

Services Provided in a Culturally Competent Manner

BCBSNM is obligated to ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. Participating providers must cooperate with Blue Cross Community Centennial in meeting this obligation.

Customer Service (the phone number is listed on the back of the member’s ID card) has the following services available for members:

- Teletypewriter (TTY) services
- Language services
- Spanish-speaking Customer Service Representatives

Continued on next page
Advance Directives

Members have the right to complete an “Advance Directive” statement. This statement indicates, in advance, the member’s choices for treatment to be followed in the event the member becomes incapacitated or otherwise unable to make medical treatment decisions. BCBSNM suggests that participating providers have Advance Directive forms in their office and available to members.

Adult members and emancipated minors have the right to have a mental health or psychiatric advance directive (PAD). For these persons with a mental illness, this directive is designed to preserve their autonomy during times when the mental illness temporarily compromises their ability to make or communicate mental health treatment decisions.

**Note:** A sample New Mexico Optional Advance Health Care Directive Form is included at the end of this Section. For more information on PADs in New Mexico and for a copy of a sample PAD form, view the NRC PAD website.

Fair Hearing

Members have the right to request a Fair Hearing through the State of New Mexico at any time in the appeal process. A member’s appeal request can be verbal or in writing. Members can have a Fair Hearing if their benefits have stopped, reduced or have been suspended. Fair Hearings are processed by the Fair Hearings Bureau at HSD/MAD, not BCBSNM.

All requests for hearings must go to the State. If a Fair Hearing is held, the decision made by the State is the final decision. BCBSNM must follow the State’s decision. If a benefit is denied, the member will receive notice from BCBSNM. BCBSNM will not retaliate against a member requesting a Fair Hearing.
### Obligation to Provide Access to Care

<table>
<thead>
<tr>
<th>Member Access to Health Care Guidelines</th>
<th>The following appointment availability and access guidelines should be used to ensure timely access to medical, dental and behavioral health care:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Routine, asymptomatic, member-initiated, outpatient appointments for primary medical care – within 30 days unless patient requests a later time</td>
</tr>
<tr>
<td></td>
<td>- Routine, symptomatic, member-initiated, outpatient appointments for non-urgent primary medical and dental care – request-to-appointment time no greater than 14 days unless patient requests a later time</td>
</tr>
<tr>
<td></td>
<td>- Non-urgent behavioral health care – request-to-appointment time no greater than 14 days unless patient requests a later time</td>
</tr>
<tr>
<td></td>
<td>- Primary medical, dental and behavioral health care outpatient appointments for urgent conditions shall be available within 24 hours</td>
</tr>
<tr>
<td></td>
<td>- Emergency care – 24 hours a day, 7 days per week</td>
</tr>
<tr>
<td></td>
<td>- Specialty outpatient referral and consultation appointments, excluding behavioral health – request-to-appointment time shall generally be consistent with the clinical urgency, but no more than 21 days, unless patient requests a later time</td>
</tr>
<tr>
<td></td>
<td>- Routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments – request-to-appointment time shall be consistent with the clinical urgency, but no more than 14 days unless patient requests a later time</td>
</tr>
<tr>
<td></td>
<td>- Outpatient diagnostic laboratory, diagnostic imaging and other testing – if a walk-in rather than an appointment system is used, the member wait time shall be consistent with the severity of the clinical need</td>
</tr>
<tr>
<td></td>
<td>- Urgent outpatient diagnostic laboratory, diagnostic imaging, and other testing – appointment availability shall be consistent with the clinical urgency, but no longer than 48 hours</td>
</tr>
<tr>
<td></td>
<td>- In-person prescription fill time (ready for pickup) shall be no longer than 40 minutes. A prescription phoned in by a practitioner shall be filled within 90 minutes.</td>
</tr>
<tr>
<td></td>
<td>- For behavioral health crisis services, face to face appointments shall be available within two hours.</td>
</tr>
<tr>
<td></td>
<td>- Sufficient transportation is available to meet the needs of the members</td>
</tr>
</tbody>
</table>

*Continued on next page*
Obligation to Provide Access to Care, Continued

<table>
<thead>
<tr>
<th>Member Access to Health Care Guidelines (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• New durable medical equipment (DME) and repairs to existing DME owned or rented by the member – approve or deny the request within seven working days of the request date.</td>
</tr>
<tr>
<td>o All new customized or made-to-measure DME or customized modifications to existing DME owned or rented by the member shall be delivered to the member within 150 days of the request date.</td>
</tr>
<tr>
<td>o All standard DME shall be delivered within 24 hours of the request, if needed on an urgent basis.</td>
</tr>
<tr>
<td>o All standard DME not needed on an urgent basis shall be delivered within a time frame consistent with clinical need.</td>
</tr>
<tr>
<td>o All DME repairs or non-customized modifications shall be delivered within 60 days of the request date.</td>
</tr>
<tr>
<td>o The MCO shall have an emergency response plan for non-customized DME needed on an emergent basis.</td>
</tr>
<tr>
<td>• The MCO shall approve or deny a request for prescribed medical supplies within seven working days of the request date. The MCO shall ensure that:</td>
</tr>
<tr>
<td>o Members can access prescribed medical supplies within 24 hours when needed on an urgent basis;</td>
</tr>
<tr>
<td>o Members can access routine medical supplies within a time frame consistent with the clinical need; and</td>
</tr>
<tr>
<td>o Subject to any requirements to procure a physician’s order to provide supplies, members utilizing medical supplies on an ongoing basis shall submit to the MCO lists of needed supplies monthly, and the MCO or its subcontractor shall contact the member if the requested supplies cannot be delivered in the time frame expected and make other delivery arrangements consistent with clinical need.</td>
</tr>
<tr>
<td>• The MCO shall ensure that members and members’ families receive proper instruction on the use of DME and medical supplies provided by the MCO/SE or its subcontractor.</td>
</tr>
</tbody>
</table>

Adherence to member access guidelines will be monitored through the office site visits and the tracking of complaints/grievances related to access and availability which are reviewed by the Clinical Quality Improvement Committee.

All participating providers will treat all members with the same dignity and consideration as they do their non-Blue Cross Community Centennial patients.
Provider Availability

Participating providers shall provide coverage 24 hours a day, 7 days a week. When a provider is unavailable to provide services, the provider must ensure that another participating provider is available. Hours of operation must not discriminate against Blue Cross Community Centennial members relative to other members. Participating providers’ standard hours of operation shall allow for appointment availability between the normal working hours of 9:00 a.m. and 5:00 p.m.

HSD requires that the member must be seen within 30 minutes of a scheduled appointment or be informed of the reason for delay (e.g. emergency cases) and be provided with an alternative appointment.

After-hours access shall be provided to ensure a response to after-hours phone calls. Individuals who believe they have an emergency medical condition should be directed to immediately seek emergency services.

Provider Office Confidentiality Statement

Members have the right to privacy and confidentiality regarding their health care records and information. Participating providers and each staff member will sign an Employee Confidentiality Statement to be placed in the staff member's personnel file.

Continued on next page
Obligation to Provide Access to Care, Continued

Patient Self-Determination Act

The PCP must comply with federal government regulations concerning the Patient Self-Determination Act (PSDA).

- PCPs must comply with all applicable state and federal laws regarding advance directives.
- PCPs must ask if adult members or emancipated minors have advance directives, and include existing advance directives in the member’s medical record.
- PCPs cannot require a member to have an advance directive in order to receive medical care, nor can they prevent a member from having an advance directive.
- Minors should not be treated without the consent of a legal guardian or legally authorized surrogate decision-maker.

Note: Medicaid does not require the consent of a legal guardian prior to services being provided for treating cases of sexually transmitted diseases, family planning, and behavioral health.

When treating Blue Cross Community Centennial members that fall under the jurisdiction of the Children, Youth, and Family Department (CYFD), Blue Cross Community Centennial case managers work in conjunction with the CYFD case workers to meet care needs.

Continued on next page
Obligation to Provide Access to Care, Continued

Prohibition against Discrimination

BCBSNM or participating providers may **not** deny, limit, or condition the coverage or furnishing of services to members on the basis of any factor that is related to health status, including, but not limited to:

- Medical condition, including behavioral as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability
- Race, ethnicity, national origin
- Religion
- Sex, sexual orientation
- Age
- Mental or physical disability
- Source of payment

Participating providers must have practice policies demonstrating that they accept for treatment any member in need of health care services they provide.

*Continued on next page*
A federal program called Vaccines for Children (VFC) provides free vaccines to eligible children, including those without health insurance coverage, those who are enrolled in Medicaid, and Native Americans. The State of New Mexico provides additional funding to purchase vaccines for all VFC-non-eligible children so that all New Mexico children from birth to 18 years old can receive free vaccines.

Providers may participate in the VFC program without participating in Medicaid if they are qualified to administer vaccines under applicable state law. However, such providers will not be reimbursed by Medicaid for their services in administering vaccines.

Under the VFC program, a provider may impose a fee for the administration of a qualified pediatric vaccine if the fee, in the case of a federally vaccine-eligible child, does not exceed the cost of such administration (as determined by the secretary based on actual regional costs for such administration). However, a provider may not deny administration of a qualified pediatric vaccine to a vaccine-eligible child due to the inability of the child’s parents or legal guardian to pay the administration fee.

BCBSNM will reimburse VFC-participating providers for vaccine administration, depending on your contracted reimbursement rate with Blue Cross Community Centennial. We encourage all contracted BCBSNM providers to participate so that all New Mexico children from birth to 18 years old receive the necessary vaccines to prevent vaccine-preventable diseases. If you have any questions about reimbursement for vaccines, please call 1-800-693-0663.
Pharmacy Services

Introduction
The following policies apply to members who have Blue Cross Community Centennial prescription benefits. Prime Therapeutics is the Pharmacy Benefit Manager (PBM) that provides drug benefits through BCBSNM for Blue Cross Community Centennial members. The PBM name is listed on the back of the member’s identification card.

Drug List
The Blue Cross Community Centennial drug list is available on the BCBSNM website at bcbsnm.com, in the Providers section under Pharmacy Program/Medicaid.

BCBSNM uses Prime Therapeutics National Pharmacy and Therapeutics (P&T) Committee, which is responsible for drug evaluation for the Medicaid drug list. The P&T Committee consists of independent practicing physicians (including behavioral health specialists) and pharmacists from throughout the country who are not employees or agents of Prime Therapeutics. BCBSNM will have one voting member on the committee. The P&T Committee meets quarterly to review new drugs and updated drug information based on the current available literature.

The HCSC Preferred Drug Committee includes clinical, marketing, and financial representation from HCSC. In conjunction with the P&T Committee, the HCSC Preferred Drug Committee determines the additions of brand-name drug products to each plan’s drug list.

BCBSNM remains responsible for the determination of benefit coverage and approvals for preauthorizations, quantity exceptions, and/or step therapy for Blue Cross Community Centennial members. BCBSNM will handle all requests for preauthorization locally.

Pharmacy preauthorizations may be requested by:
- Submitting an electronic preauthorization request for drugs covered under the pharmacy benefit through CoverMyMeds®
- Submitting an electronic preauthorization request for drugs covered under the medical benefit through iExchange
- Faxing a request to 505-816-3867
- Calling Medicaid Health Services at 1-877-232-5518

Continued on next page
Pharmacy Services, Continued

**Drug List (continued)**

BCBSNM provides notification to Blue Cross Community Centennial members and physicians of additions and changes made to the Blue Cross Community Centennial drug list by direct mailings, newsletters, and on the BCBSNM website. The drug list is updated quarterly and a link to the updates is published in the *Blue Review*.

Members who are identified as taking a medication that has been deleted from the BCBSNM drug list are sent a letter detailing the change at least 30 days prior to the deletion effective date. BCBSNM and Prime Therapeutics also provide pharmaceutical safety notification to dispensing providers for members regarding point-of-dispensing drug-drug interaction, and FDA drug recalls.

The Blue Cross Community Centennial drug list is provided as a guide to our participating providers to help them in selecting cost-effective drug therapy. Members have a closed pharmacy benefit. **Non-formulary drugs are generally considered not a covered benefit.** Most generics and listed brand name products are covered. A copay may apply if required by the member’s benefit plan. A copay may also apply when a generic is available and a brand-name drug is dispensed (see “Covered and Non-covered Pharmacy Services” for details). Please refer to the Blue Cross Community Centennial drug list when prescribing for our members.

**Generic Drugs**

The FDA has a process to assign equivalency ratings to generic drugs. An “A” rating means that the drug manufacturer has submitted documentation demonstrating equivalence of its generic product compared to the brand name product.

BCBSNM supports the FDA process for determining equivalency and strongly advises its participating providers to prescribe drugs that have generic alternatives available. Blue Cross Community Centennial is a “generics first” program. Requests for brand-name agents will be considered on a case-by-case basis (via the standard preauthorization process) and require written documentation that the member has been unable to tolerate multiple generic agents or that multiple generics have been ineffective in treating the member’s condition.

*Continued on next page*
Blue Cross Community Centennial Plan

Pharmacy Services, Continued

Drug Utilization Review

BCBSNM and Prime Therapeutics conduct prospective, concurrent, and retrospective Drug Utilization Reviews (DUR) for Blue Cross Community Centennial members to ensure the most appropriate and cost-effective drugs are used safely. Prospective DUR entails provider education through newsletters and personal contact by employees of the plan.

Concurrent DUR occurs at the point of sale (i.e., at the dispensing pharmacy). Pharmacies are electronically linked to Prime Therapeutics’ claims adjudication system. This system contains various edits that check for drug interactions, over-utilization (i.e., early refill attempts), drug interactions, and therapeutic duplications. The system also alerts the pharmacist when the prescribed drug may have an adverse effect if used by elderly or pregnant members. The pharmacist can use his or her professional judgment and call the prescribing provider if a potential adverse event may occur.

Retrospective DUR uses historical prescription claims data and may address a wide range of medication therapy issues. The data is evaluated to determine compliance with the clinical practice guidelines approved by the P&T Committee. Individual letters are mailed to providers with members identified as potential drug therapy concerns, together with a profile listing the prescription medications filled during the study period, and a response form to be mailed or faxed to the BCBSNM PBM. A provider’s timely response is very important to BCBSNM.

Guided HealthSM (offered through our PBM) is a drug utilization platform that has the ability to integrate medical and pharmacy data to facilitate better outcomes, improve medication adherence, and avoid adverse events. Guided Health supplies providers with a single tool that identifies multiple member-specific medication issues.

BCBSNM also supplies other provider-facing communications to assist with medication therapy management, including mailings/electronic notifications that address topics such as polypharmacy, asthma adherence, and drug-specific laboratory monitoring.

Continued on next page
Pharmacy Services, Continued

The following list describes the typically covered and non-covered Blue Cross Community Centennial pharmacy services. The member’s applicable prescription copay applies for each prescription or refill for 30 days or 120 units, whichever is less. One applicable copay applies to most “packaged” items (e.g., inhalers).

**Note:** Members eligible for Medicaid may be assessed a copay for each prescription as required by the benefit plan.

A copay for unnecessary use of a brand name drug applies when a branded drug with a therapeutically equivalent generic drug is dispensed. This copay does not apply to legend drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions. Copayments do not apply to Native Americans.

**Covered Pharmacy Services**
- Generic drugs
- Branded drugs as identified in the Medicaid drug list
- Glucagon and anaphylactic kits
- Insulin, syringes, lancets, and test strips
- Oral contraceptives
- Plan B (dispensing limits apply)
- Diaphragms and condoms
- Over-the-counter (OTC) medications (selected products only)

**Note:** Blue Cross Community Centennial has contracted (through our Pharmacy Benefit Manager, Prime Therapeutics) with Rx Innovations, Inc. to deliver “bubble-packed” medications to members that require special assistance in managing complicated prescription drug regimens. This packaging simplifies medication administration by combining all scheduled medications into a single “bubble” for each dosing interval (such as morning, noon, evening, and bedtime). Additionally, the pharmacy is able to deliver traceable packages to rural locales via UPS. Rx Innovations, Inc. may be contacted at: **505-881-4601**.
Pharmacy Services, Continued

Covered & Non-covered Pharmacy Services (continued)

Non-covered Pharmacy Services
- Non-formulary medications (without preauthorization)
- Any charge for most therapeutic devices or appliances (e.g., support garments and other non-medical substances), regardless of their intended use
- Investigational use of medication
- Medications specifically excluded from benefit (e.g., drugs used for cosmetic purposes and infertility)
- Certain injectable drugs (other than insulin, glucagon, and anaphylactic kits) that are obtained at a pharmacy without preauthorization from the BCBSNM Health Services department. (Injectables received through a member’s physician are covered if the drug meets all other criteria for coverage.)
- Nutritional supplements (coverage may require preauthorization)
- Prescriptions obtained at an out-of-network pharmacy, unless in an emergency
- Take-home drugs provided by a provider’s office
- Lost, stolen, damaged, or destroyed medications
- Drug Efficiency Study and Implementation (DESI) medications

Drugs Requiring Pre-authorization

Drugs with a high potential for experimental or off-label use may require preauthorization. Review the Drug List Limitations, Exclusions, and Prior Authorization Criteria for detailed preauthorization requirements.

BCBSNM allows for certain off-label uses of drugs when the off-label uses meet the requirements of the BCBSNM policy. Please contact the Medicaid Health Services department for more information on the BCBSNM off-label and investigational use policy.

Continued on next page
Pharmacy Services, Continued

**Pharmacy Network**

BCBSNM members with a “pharmacy card” prescription drug benefit must use a pharmacy on the approved list of participating pharmacies. Most pharmacies in New Mexico, including Indian Health Service pharmacies, are contracted to provide pharmacy services under Blue Cross Community Centennial. Members who are referred for treatment outside New Mexico may also access pharmacies that are contracted in the PBM’s national network. Please encourage your patients to use one pharmacy for all of their prescriptions to better monitor drug therapy and avoid potential drug-related problems.

BCBSNM contracts with Prime Therapeutics for mail-order pharmacy services (PrimeMail) and allows members of Blue Cross Community Centennial to receive up to a 90-day supply of maintenance medication (e.g., drugs for arthritis, depression, diabetes, or hypercholesterolemia). If you believe that a Blue Cross Community Centennial member will continue on the same drug and dose for an indefinite period of time, please consider writing the prescription for a 90-day supply with three refills. All new prescription therapy will be restricted to a 30-day supply on the initial fill to help ensure the drug is tolerated.

**Note:** Native Americans may receive a 90-day supply of medication at an Indian Health Service pharmacy without being restricted to a 30-day supply on the initial fill and without approval from BCBSNM.

High-risk drugs that are FDA approved for patient self-administration must be acquired through a specialty pharmacy provider.

*Continued on next page*
Pharmacy Services, Continued

Specialty medications are used to treat serious or chronic conditions such as multiple sclerosis, hemophilia, hepatitis C, and rheumatoid arthritis. These medications are often injectable and can be administered by the patient or a family member. One or more of the following may also be true about these medications:

- They are generally injected, but some may be taken by mouth
- They have unique storage or shipment requirements
- Additional education and support is required from a health care professional
- Frequently are not stocked at retail pharmacies

All specialty medications require preauthorization. Blue Cross Community Centennial members must use contracted specialty network pharmacies to fill their prescriptions. The pharmacists, nurses, and care coordinators in our specialty network pharmacies are experts in supplying medications and services to patients with complex health conditions.

For those medications that are FDA approved for self-administration, members are required to use their pharmacy benefit and acquire the medication through contracted specialty network pharmacies – not dispensed through the physician’s office. Self-administered drugs can include oral, patch and injectable products.

Prime Specialty Pharmacy is the preferred specialty pharmacy for most BCBSNM members. To obtain specialty medications through the Specialty Pharmacy program (after preauthorization is obtained):

1. **Collect patient and insurance information**
   Use the Prime Specialty Pharmacy fax form or your own prescription form, along with your office’s fax cover sheet. Be sure to include the physician’s signature and any clinical data that may support the approval process.

2. **Fax signed forms to 877-243-6930**
   Prime Specialty Pharmacy’s team of pharmacists and benefit specialists will handle the details, from checking eligibility to coordinating delivery.
Prime Specialty Pharmacy provides safe and efficient delivery of specialty medications and integrated management across medical and pharmacy benefits. As a service to your patients, Prime Specialty Pharmacy can deliver those drugs that are approved for self-administration directly to the patient’s home or alternate location. Please note that Prime is also available for those specialty medications that are covered under the member’s medical benefit.

Covered specialty drugs are listed on the Medicaid Drug List on our website at bcbsnm.com, in the Pharmacy/Medicaid section.

For more information, contact Prime at 1-877-627-6337.

CoverMyMeds is a registered trademark of CoverMyMeds LLC, an independent third party vendor that is solely responsible for its products and services.

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSNM contracts with Prime to provide pharmacy benefit management, prescription home delivery and specialty pharmacy services. BCBSNM, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSNM. BCBSNM makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors such as Availity. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

Please note that the fact that a service has been preauthorized/pre-certified is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member’s eligibility and the terms of the member’s certificate of coverage applicable on the date services were rendered. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.
# Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Abuse</td>
<td>(i) any intentional, knowing or reckless act or failure to act that produces or is likely to produce physical or great mental or emotional harm, unreasonable confinement, sexual abuse or sexual assault consistent with the Resident Abuse and Neglect Act, NMSA 1978, 30-47-1, et seq.; or (ii) provider practices that are inconsistent with sound fiscal, business, medical or service-related practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary Services or that fail to meet professionally recognized standards for health care. Abuse also includes member practices that result in unnecessary cost to the Medicaid program pursuant to 42 C.F.R. § 455.2.</td>
</tr>
<tr>
<td>Advance Directives</td>
<td>Advance Directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under the law of the State of New Mexico and signed by a patient, that explain the patient’s wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known. Advance directives may also be utilized to provide advance instructions regarding mental health treatment decisions. Note: A sample New Mexico Optional Advance Health Care Directive Form is included at the end of this Section.</td>
</tr>
<tr>
<td>Appeal</td>
<td>A request for review by BCBSNM for services for a member that are reduced, denied or limited, or a request for review where BCBSNM did not complete an authorization on time.</td>
</tr>
<tr>
<td>Behavioral Health Planning Council (BHPC)</td>
<td>The body created to meet federal and state advisory council requirements and to provide consistent, coordinated input to the behavioral health service delivery system in New Mexico.</td>
</tr>
<tr>
<td>Blue Cross Community Centennial</td>
<td>The Medicaid managed care program.</td>
</tr>
<tr>
<td>Copayment</td>
<td>The portion of the claim or medical expense that members must pay out of their pocket for the services.</td>
</tr>
<tr>
<td>Collaborative</td>
<td>The interagency behavioral health purchasing collaborative, established under NMSA 1978, § 9-7-6.4, responsible for planning, designing and directing a statewide Behavioral Health system.</td>
</tr>
<tr>
<td>Term</td>
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<tr>
<td>Core Service Agencies (CSA)</td>
<td>Multi-service agencies that help to bridge treatment gaps in the child and adult treatment systems, promote the appropriate level of service intensity for members with complex behavioral health service needs, ensure that community support services are integrated into treatment, and develop the capacity for members to have a single point of accountability for identifying and coordinating their behavioral health, health and other social services.</td>
</tr>
<tr>
<td>Covered Services</td>
<td>Services covered as defined in the Blue Cross Community Centennial Provider Reference Manual, the Medical Assistance Division Program Policy Manual, or other applicable rules, regulations, or guidelines.</td>
</tr>
</tbody>
</table>
| Emergency Medical Condition               | Medical or behavioral health conditions manifesting themselves by acute symptoms of sufficient (including severe pain), that would lead a prudent layperson possessing an average knowledge of medicine and health to reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in:  
  - Serious jeopardy of the patient’s health  
  - Serious impairment to bodily functions  
  - Serious dysfunction of any bodily organ or part  
  - Serious disfigurement                                                                 |
| External Quality Review Organization (EQRO)| The External Quality Review Organization (EQRO) retained by HSD/MAD. HealthInsight New Mexico is the EQRO for Blue Cross Community Centennial.                                                                 |
| Grievance                                 | Any expression of dissatisfaction about any matter or aspect of BCBSNM or its Blue Cross Community Centennial operation.                                                                                   |
| Health Home                               | As defined in section 2703 of PPACA, an individual provider, team of health care professionals, or health team that meets all federal requirements and provides the following six services to persons with one or more specified chronic conditions: (i) comprehensive care management; (ii) care coordination and health promotion; (iii) comprehensive transitional care/follow-up; (iv) patient and family support; (v) referral to community and social support services; and (vi) use of Health Information Technology (HIT) to link services, if applicable. |
| HSD                                       | New Mexico Human Services Department                                                                                                            |
| HIPAA                                     | Health Insurance Portability and Accountability Act and its implementing regulation, as amended                                                   |
## Glossary of Terms, Continued

<table>
<thead>
<tr>
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<tr>
<td>MAD</td>
<td>Medical Assistance Division</td>
</tr>
<tr>
<td>Member</td>
<td>A recipient who is currently enrolled in the Blue Cross Community Centennial plan.</td>
</tr>
<tr>
<td>MHSIP</td>
<td>The mental health statistics improvement project.</td>
</tr>
<tr>
<td>PAD</td>
<td>Psychiatric advance directive</td>
</tr>
<tr>
<td>Participating Provider</td>
<td>Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the State of New Mexico and Medicaid to deliver or furnish health care services. This individual or institution has a written agreement to provide services directly or indirectly to Blue Cross Community Centennial members pursuant to the terms of the Agreement.</td>
</tr>
<tr>
<td>Primary Care</td>
<td>All health and laboratory services customarily furnished by a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or certified nurse practitioner.</td>
</tr>
<tr>
<td>Primary Care Provider (PCP)</td>
<td>A provider who agrees to manage and coordinate the care provided to members.</td>
</tr>
<tr>
<td>SED</td>
<td>Serious emotional disturbance</td>
</tr>
<tr>
<td>SPMI</td>
<td>Severe persistent mental illness</td>
</tr>
<tr>
<td>State</td>
<td>Refers to the State of New Mexico</td>
</tr>
</tbody>
</table>

For additional procedures and information, please refer to the *BCBSNM Blues Provider Reference Manual.*
<table>
<thead>
<tr>
<th><strong>Blue Cross Community Centennial Contacts List</strong></th>
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<tbody>
<tr>
<td><strong>Availity</strong></td>
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<tr>
<td><strong>Behavioral Health</strong></td>
</tr>
<tr>
<td><strong>Claims Address</strong></td>
</tr>
<tr>
<td><em>(For submission of paper claims)</em></td>
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<tr>
<td><strong>Case Management (CM) Programs</strong></td>
</tr>
<tr>
<td><strong>Case Management Programs Fax</strong></td>
</tr>
<tr>
<td><strong>Condition Management/Disease Management Programs</strong></td>
</tr>
<tr>
<td><strong>Condition Management/Disease Management Programs Fax</strong></td>
</tr>
<tr>
<td><strong>Community Social Services</strong></td>
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<tr>
<td><strong>Davis Vision</strong></td>
</tr>
<tr>
<td><strong>DentaQuest</strong></td>
</tr>
<tr>
<td><strong>Electronic Claim Questions or Problems</strong></td>
</tr>
<tr>
<td><strong>Fraud Hotline BCBSNM Special Investigations Department (to report suspected fraud and abuse)</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Language Interpreter Line</strong></td>
</tr>
<tr>
<td>• Relay NM (TTY deaf, hearing and/or speech impaired) available in Spanish upon request</td>
</tr>
<tr>
<td>• Bilingual (English-Spanish) Customer Service</td>
</tr>
<tr>
<td><strong>LogistiCare (Transportation services)</strong></td>
</tr>
<tr>
<td><strong>Network Services Representative</strong></td>
</tr>
<tr>
<td><strong>Pharmacy Utilization Management Intake</strong></td>
</tr>
<tr>
<td><strong>Prime Pharmacy Help Desk</strong></td>
</tr>
<tr>
<td><strong>Provider Customer Service (claims, benefits, etc.)</strong></td>
</tr>
<tr>
<td><strong>Provider One Call</strong></td>
</tr>
<tr>
<td><strong>Provider Resources</strong></td>
</tr>
<tr>
<td><strong>Quality Improvement Department</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Utilization Management (UM)</strong></td>
</tr>
<tr>
<td>• Preauthorization and Out-of-Network Referrals</td>
</tr>
<tr>
<td>• Preauthorization Fax</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>• Utilization Management Member Appeals</td>
</tr>
</tbody>
</table>
ATTACHMENT SECTION FOLLOWS
New Mexico Optional Advance Health Care Directive Form
EXPLANATION FOR MEMBERS

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician.

THIS FORM IS OPTIONAL. Each paragraph and word of this form is also optional. If you use this form, you may cross out, complete or modify all or any part of it. You are free to use a different form. If you use this form, be sure to sign it and date it.

PART 1 of this form is a power of attorney for health care. PART 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator or employee of a health care institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;
2. Select or discharge health care providers and institutions;
3. Approve or disapprove diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and
4. Direct the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

PART 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding life-sustaining treatment, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. In addition, you may express your wishes regarding whether you want to make an anatomical gift of some or all of your organs and tissue. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

PART 3 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. It is recommended but not required that you request two other individuals to sign as witnesses. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.
PART 1
POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

______________________________________________________________________

(name of individual you choose as agent)

______________________________________________________________________

(address)        (city)                (state)               (zip code)

______________________________________________________________________

(home phone)                     (work phone)

If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health care decision for me, I designate as my first alternate agent:

______________________________________________________________________

(name of individual you choose as first alternate agent)

______________________________________________________________________

(address)        (city)                (state)             (zip code)

______________________________________________________________________

(home phone)                   (work phone)

If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health care decision for me, I designate as my second alternate agent:

______________________________________________________________________

(name of individual you choose as second alternate agent)

______________________________________________________________________

(address)        (city)                (state)              (zip code)

______________________________________________________________________

(home phone)                  (work phone)

(2) AGENT'S AUTHORITY: My agent is authorized to obtain and review medical records, reports and information about me and to make all health care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition, hydration and all other forms of health care to keep me alive, except as I state here:

______________________________________________________________________

(Add additional sheets if needed.)

(3) WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician and one other qualified health care professional determine that I am unable to make my own health care decisions. If I initial this box [________], my agent's authority to make health care decisions for me takes effect immediately.
(4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this
power of attorney for health care, any instructions I give in Part 2 of this form and my other wishes to the
extent known to my agent. To the extent my wishes are unknown, my agent shall make health care
decisions for me in accordance with what my agent determines to be in my best interest. In determining
my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I
nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act
as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2
INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions,
you need not fill out this part of the form. If you do fill out this part of the form, you may cross out any
wording you do not want.

(6) END-OF-LIFE DECISIONS: If I am unable to make or communicate decisions regarding my health
care, and IF (i) I have an incurable or irreversible condition that will result in my death within a relatively
short time, OR (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not
regain consciousness, OR (iii) the likely risks and burdens of treatment would outweigh the expected
benefits, THEN I direct that my health care providers and others involved in my care provide, withhold or
withdraw treatment in accordance with the choice I have initialed below in one of the following three
boxes:

[____] I CHOOSE NOT To Prolong Life
   I do not want my life to be prolonged.

[____] I CHOOSE To Prolong Life
   I want my life to be prolonged as long as possible within the limits of generally accepted health
care standards.

[____] I CHOOSE To Let My Agent Decide
   My agent under my power of attorney for health care may make life-sustaining treatment decisions
   for me.

(7) ARTIFICIAL NUTRITION AND HYDRATION: If I have chosen above NOT to prolong life, I also
specify by marking my initials below:

[____] I DO NOT want artificial nutrition OR

[____] I DO want artificial nutrition.

[____] I DO NOT want artificial hydration unless required for my comfort OR

[____] I DO want artificial hydration.
(8) RELIEF FROM PAIN: Regardless of the choices I have made in this form and except as I state in the following space, I direct that the best medical care possible to keep me clean, comfortable and free of pain or discomfort be provided at all times so that my dignity is maintained, even if this care hastens my death:

______________________________________________________________________
______________________________________________________________________

(9) ANATOMICAL GIFT DESIGNATION: Upon my death I specify as marked below whether I choose to make an anatomical gift of all or some of my organs or tissue:

[___] I CHOOSE to make an anatomical gift of all of my organs or tissue to be determined by medical suitability at the time of death, and artificial support may be maintained long enough for organs to be removed.

[___] I CHOOSE to make a partial anatomical gift of some of my organs and tissue as specified below, and artificial support may be maintained long enough for organs to be removed.

______________________________________________________________________
______________________________________________________________________

[___] I REFUSE to make an anatomical gift of any of my organs or tissue.

[___] I CHOOSE to let my agent decide.

(10) OTHER WISHES: (If you wish to write your own instructions, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

______________________________________________________________________

(Add additional sheets if needed.)

PART 3 PRIMARY PHYSICIAN

(11) I designate the following physician as my primary physician:

__________________________________________
(name of physician)

__________________________________________
(address) (city) (state) (zip code)

__________________________________________
(phone)
If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

______________________________________________________________________
(name of physician)
______________________________________________________________________
(address) (city) (state) (zip code)
______________________________________________________________________
(phone)

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) REVOCATION: I understand that I may revoke this OPTIONAL ADVANCE HEALTH CARE DIRECTIVE at any time, and that if I revoke it, I should promptly notify my supervising health care provider and any health care institution where I am receiving care and any others to whom I have given copies of this power of attorney. I understand that I may revoke the designation of an agent either by a signed writing or by personally informing the supervising health care provider.

(14) SIGNATURES: Sign and date the form here:

______________________________________________________________________
(date) (sign your name)
______________________________________________________________________
(address) (print your name)
______________________________________________________________________
(city) (state) (your social security number)

(Optional) SIGNATURES OF WITNESSES:
First witness: Second witness:

______________________________________________________________________
(print name) (print name)
______________________________________________________________________
(address) (address)
______________________________________________________________________
(city) (state) (city) (state)
______________________________________________________________________
(signature of witness) (signature of witness)
______________________________________________________________________
(date) (date)
Provider Disclosure of Ownership and Control Interest Form

This form is for groups, organizations or individuals directly contracted with Blue Cross and Blue Shield of New Mexico (BCBSNM) to whom or which payments will be made ("Disclosing Provider"). Such Disclosing Provider should please collect the information set forth in this form and return it to BCBSNM once completed and signed. Individual providers who bill for services through a group practice or organization contracted with BCBSNM need not separately or individually complete this form. Regulatory definitions may be found at 42 CFR Section 455.101, et seq.

<table>
<thead>
<tr>
<th>Name of Disclosing Provider (Directly Contracted with BCBSNM)</th>
<th>Tax ID Number</th>
<th>NPI</th>
</tr>
</thead>
</table>

1. CRIMINAL CONVICTIONS (42 CFR Section 455.106)

Has the Disclosing Provider, or any “person who has ownership or control interest” in the Disclosing Provider, or any person who is an “agent” or “managing employee” of the Disclosing Provider, been convicted of a CRIMINAL OFFENSE related to that person's involvement in any program under Medicare, Medicaid, or the Title XX (Block Grants to States for Social Services) since the inception of those programs? (Definitions may be found at 42 CFR Sections 101, et seq.). If yes, give the name(s) of person(s) and description(s) of offense(s). Please use additional pages if necessary.

<table>
<thead>
<tr>
<th>Name of Criminal Offender</th>
<th>TIN or SSN</th>
<th>Date of Birth</th>
<th>Description of Offenses</th>
</tr>
</thead>
</table>

2. MANAGING EMPLOYEES (42 CFR Section 455.104(b)(4))

Definition: A managing employee is a "general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency." Managing employees are in a position to exert influence over the conduct of the Disclosing Provider's operations and includes officers, governing boards, or board of directors.

New Mexico Human Services Department, Medical Assistance Division requires the following information to be disclosed on all managing employees of the disclosing provider. Please use additional pages if necessary.

<table>
<thead>
<tr>
<th>Name of Managing Employee</th>
<th>SSN</th>
<th>Address(es)</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

3. OWNERSHIP AND CONTROL (42 CFR Section 455.104(b)(i)(ii) and (iii))

Definitions: Person with an ownership or control interest generally means a person or corporation that (i) has an ownership interest of at least 5 percent in the Disclosing Provider; or (ii) is an officer or director of, or partner in, the Disclosing Provider. Ownership means possession of equity in the capital, stock, or profits of the Disclosing Provider. The 5 percent ownership threshold may be met by direct or indirect ownership, or combination of the two. Indirect ownership means an ownership interest in an entity that has an ownership interest in the Disclosing Provider.

Provide the name and address of each person (i) with an ownership or control interest in the Disclosing Provider or, (ii) in any subcontractor in which the Disclosing Provider has direct or indirect ownership of five percent or more. For corporations that have an ownership or control interest in the Disclosing Provider, please separately list its primary business address, every business location and post office box address. Please use additional pages if necessary.
<table>
<thead>
<tr>
<th>Name of Person with Ownership or Control Interest</th>
<th>TIN or SSN</th>
<th>Address(es)</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
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</table>

4. OWNERSHIP AND CONTROL – RELATIVES (42 CFR Section 104(b)(2))

Is any person named in question #3 related to another person also named in question #3 as spouse, parent, child, or sibling? If yes, give the name(s) of person(s) and relationship(s). Please use additional pages if necessary.

*Note: Designate relationship to each person listed in question #3.*

<table>
<thead>
<tr>
<th>Name of Responsive Person from Question #3, if any</th>
<th>Relationship to Other Person from Question #3, if any</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

5. OWNERSHIP AND CONTROL – OTHER PROVIDERS AND ENTITIES (42 CFR Section 455.104(b)(3))

Does any person named in question #3 have an ownership or control interest in any Medicaid provider other than the Disclosing Provider identified at the top of this form or in any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V (Maternal and Child Health Services Block Grant), XVII (Grants for Planning Comprehensive Action to Combat Mental Retardation), or XX (Block Grants to States for Social Services) of the Social Security Act ("Other Disclosing Entity")? If yes, provide the information below. Please use additional pages if necessary.

<table>
<thead>
<tr>
<th>Name of Responsive Person from Question #3, if any</th>
<th>Name, Address and Medicaid Provider ID Number of Medicaid Provider (other than Disclosing Provider identified at the top of this form) or Other Disclosing Entity in which Person from Question #3 has ownership or control interest, if any.</th>
</tr>
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**Certification:**

I certify that the above disclosed information is true and correct to the best of my knowledge as of the date set forth below. I further understand that payment of claims will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State Law.

________________________  ____________________________
Signature                                           Date

________________________
Title

________________________
Printed name

Return your completed form to:
Blue Cross and Blue Shield of New Mexico
Attn: Network Services Department
P.O. Box 27630
Albuquerque, NM 87125-7630

Or Fax to: 1-866-290-7718 or 505-816-2688

Rev. 09/08/14